

PROBLEMS AND TREATMENT OF
ALCOHOLISM AND
DRUG ABUSE



Bulletin No. 79-15

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
CARSON CITY, NEVADA

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FILE NUMBER.....

SENATE CONCURRENT RESOLUTION—Directing the legislative commission to study the problems and treatment of alcoholism and drug abuse in Nevada and the feasibility of requiring health insurance to cover treatment thereof.

WHEREAS, Alcoholism is a nagging physical and social problem which affects the lives of many Nevadans; and

WHEREAS, The low priority which has been given to this problem at the state level has stagnated attempts to provide Nevada with the necessary knowledge of dealing with and treating alcoholism; and

WHEREAS, Alcohol and alcohol abuse cost the people of Nevada \$25,000,000 annually in lost work time through accidents, absenteeism and impaired performance; and

WHEREAS, The combined problem of alcoholism and drug abuse should be considered and the possibility of requiring the coverage of treatment for alcoholism and drug abuse in health insurance policies studied; now, therefore, be it

Resolved by the Senate of the State of Nevada, the Assembly concurring, That the legislative commission is hereby directed to study the problems and treatment of alcoholism and drug abuse and to make a comprehensive study of the feasibility of requiring health insurance policies to cover treatment for alcoholism and drug abuse, including the effect on premium, policy structure and indirect costs; and be it further

Resolved, That the committee report the results of its findings along with recommendations to the 60th session of the Nevada legislature.

REPORT OF THE LEGISLATIVE COMMISSION

TO THE MEMBERS OF THE 60TH SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Senate Concurrent Resolution No. 34 of the 1977 legislative session which directed the legislative commission to study the problems of alcoholism and drug abuse in Nevada, with particular emphasis on " * * * the feasibility of requiring health insurance policies to cover treatment for alcoholism and drug abuse * * * "

S.C.R. 34 was designated by the legislative commission as a staff study with a legislative oversight subcommittee appointed to direct staff and make policy decisions. Assemblyman Robert E. Price chaired the oversight subcommittee and was assisted by Senator Eugene V. Echols.

The subcommittee wishes to acknowledge persons who participated in meetings and opened facilities for tours. In addition, the subcommittee extends its appreciation to both the state insurance division and the bureau of alcohol and drug abuse for their considerable contributions.

The report is transmitted to members of the 1979 legislature for their consideration.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

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SUMMARY OF RECOMMENDATIONS

The oversight subcommittee recommends that:

1. The legislature enact legislation mandating health insurance coverage of alcoholism treatment in new and renewed group policies, medical service corporation contracts and health maintenance plans. The effective date of the law should be 1980 to give the insurance commission and insurers time to prepare for the change. At this time, individual health insurance policies should not be required to include benefits for substance abuse coverage primarily because of substantially higher costs than anticipated in group type policies.
2. The legislation which mandates coverage of alcoholism of treatment in group health insurance policies should:
 - a. Require a minimum of 5 days acute hospital care, 30 days inpatient treatment, in a health and care facility and in major medical policies, 52 visits of outpatient care. Family counseling shall be allowed under outpatient benefits.
 - b. Limit required coverage to a lifetime maximum of two treatment periods, each one consisting of the day limits mentioned in the previous recommendation. A lifetime reserve of 60 outpatient visits shall be included in the minimum required coverage.
 - c. On a temporary basis the lifetime dollar benefit maximums should remain as they are in existing law--\$1,000 for inpatient care in a health and care facility and \$800 for outpatient treatment. An advisory task force should be created to:
 - (1) Make recommendations to the 1981 legislature on appropriate dollar maximum benefit levels for the mandatory alcoholism coverage and on standards for determining these benefit levels.
 - (2) Advise the insurance division on implementing the mandatory alcoholism benefits law.

- (3) Review the Nevada "credentialling" model for substance abuse programs and, if necessary, recommend changes to the bureau of alcohol and drug abuse.

Members of the advisory task force should be appointed to serve in the interim between enactment of the law and the 1981 legislative session.

The advisory task force shall be composed of:

- 1 legislator appointed by the legislative commission
- 1 representative from the insurance division
- 1 representative from the bureau of alcohol and drug abuse
- 1 representative of the health insurance industry
- 1 consumer

With the exception of the legislative member, task force members shall be appointed by the governor.

3. Not require aftercare as a consideration for reimbursement.
4. Certification of staff, program accreditation and facility licensure by the state should be prerequisites for participation in the mandatory insurance program.
5. Inpatient alcoholism care facilities, with medical supervision (not necessarily on the premises) and with highly structured rehabilitation programs, should be covered by 439A of NRS. The intent is to exclude less formal half-way houses or residential facilities.
6. Insurers should be required to offer individual policyholders alcoholism benefits equal to those mandated by group type policies.
7. Optional drug abuse benefits equal to mandatory alcoholism benefits should be required to be offered in individual and group health insurance policies, medical service corporation contracts and health maintenance plans.

I. INTRODUCTION

The 1977 Nevada legislature adopted Senate Concurrent Resolution 34 which directs the legislative commission to study the problems and treatment of alcoholism and drug abuse. The primary charge of that resolution is "to make a comprehensive study of the feasibility of requiring health insurance policies to cover treatment for alcoholism and drug abuse* * * ."

Pursuant to S.C.R. 34, the legislative commission assigned staff from the research division of the legislative counsel bureau to perform the study. A legislative oversight subcommittee was designated to direct staff and provide guidance for policy decisions. Members of the oversight subcommittee were Assemblyman Robert E. Price (Clark County), chairman and Senator Eugene V. Echols (Clark County). Assemblyman James N. Kosinski (Washoe County) sat with the oversight subcommittee in an unofficial capacity.

II. PROCEDURES

The oversight subcommittee took a very active role in determining study activities. On November 4, 1977, subcommittee and staff visited substance abuse treatment centers in Washoe County and Fallon. The following day, November 5, 1977, was spent in public hearings in Carson City. The subcommittee heard statements from state and local alcohol and drug abuse administrators, the Health Insurance Association of America, the state insurance division, the Nevada industrial commission, the state personnel division, the Nevada mental health institute, the state employment security department, a representative of a local school district, private employers and the state office of traffic safety. On January 13, 1978, the subcommittee toured substance abuse treatment centers in Clark County and then convened on January 14, 1978, for a public hearing. Those speaking before the subcommittee included insurance representatives, treatment center staff, a representative of liquor wholesalers, a Nevada municipal judge, juvenile court staff and a representative of the Clark County school district.

In addition to public hearings, information on the feasibility of mandating health insurance coverage of substance abuse was solicited in three surveys:

1. A 1977 legislative counsel bureau staff survey of other states' legislation;

2. A 1978 survey by the state insurance division of other selected state insurance commissions; and
3. A 1978 joint survey by legislative counsel bureau staff and the state insurance division of 10 large health insurers in Nevada.

Finally, the literature in the field was researched for information on third-party coverage of the costs of alcohol and drug abuse treatment. Many of these reports were supplied by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA).

On June 24, 1978, the oversight subcommittee and staff met in work session in North Las Vegas to prepare recommendations to the legislative commission. The final work session to approve the report and proposed legislation took place on July 24, 1978, also in North Las Vegas.

III. BACKGROUND

The S.C.R. 34 study evolved after several sessions of legislative interest in substance abuse and insurance. In 1971, the Nevada legislature enacted A.B. 416 (NRS 689A.280) which allows insurers to include provisions in policies exempting them from liability for losses sustained because an insured person is intoxicated or under the influence of drugs.

The 1975 legislature considered two bills on the subject of health insurance and treatment of substance abuse. A.B. 631 would have prohibited any health insurance policy from being issued unless it provided benefits for treatment of alcoholism and drug abuse. The bill which passed, S.B. 588 (incorporated into NRS 689A and 689B and NRS 695B and 695C), mandates health insurance benefits for treatment of alcoholism and drug abuse, at the option of the policy applicant. Basically, the law simply encourages such coverage by requiring that it be offered. That law also stated that insurance policies with liability exemptions for losses attributed to substance abuse must still pay treatment benefits if such policies cover substance abuse as an illness. (See Appendix A, p. 46.)

In 1977 the Nevada legislature rejected S.B. 182 which would have made health insurance coverage of substance abuse mandatory in all health insurance policies issued in the state. In addition, the bill would have liberalized benefits for substance

abuse treatment by extending the number of days covered and by removing maximum dollar expenditures covered. S.B. 182 would have removed the clause in NRS which allows insurers to exclude losses due to intoxicification.

Thus the S.C.R. 34 study was born out of questions and issues raised about costs and other impacts of S.B. 182.

IV. FEASIBILITY OF MANDATORY HEALTH INSURANCE COVERAGE

A. Review of the Literature

Staff conducted a review of the literature on alcoholism and drug abuse concentrating on studies relating to health insurance coverage.

1. Substance Abuse and Illnesses

The first studies examined concerned themselves with overall sickness and absenteeism rates of alcoholics. Occupational health researchers Pell and D'Alonzo derived evidence from the DuPont Company's medical program which indicates that alcoholic employees have greater sickness and absenteeism rates than non-alcoholics. Specifically, alcoholics were absent because of respiratory infections (upper respiratory, influenza, bronchitis and pneumonia) almost twice as often as a control group without known or suspected alcoholism. Alcoholics had almost three times the absenteeism rate for musculoskeletal disorders (arthritis, rheumatism, low back disorders, bursitis, disc disorders and muscular strain) as did nonalcoholics. Digestive disorders caused absenteeism 2.4 times as often among alcoholics as nonalcoholics. Absenteeism attributed to accidents was 3.5 times greater for alcoholics than for members of the control group. (See Appendix B, page 49.) Alcoholics exceed nonalcoholics in both frequency and duration of absences from work by a ratio of 2 to 1.¹

An earlier Pell and D'Alonzo study of DuPont employees with drinking problems also revealed interesting information about the relationship of alcoholism to other illnesses. Over 900

¹Sidney Pell and C. A. D'Alonzo, "Sickness Absenteeism of Alcoholics," Journal of Occupational Medicine, Vol. 12 (June, 1970), 198-210.

known persons with arrested alcoholism, unarrested alcoholism and suspected alcoholism were paired with the same number of control individuals matched by age, sex, occupation and geographical location. Findings revealed that hypertension, stomach and duodenum ulcers, kidney stones, neuritis and liver cirrhosis were significantly higher among problem drinkers than among controls.²

No studies were reviewed which relate drug abuse to other illnesses.

The reasons for showing the relationship of substance abuse to other illnesses are twofold. First, it is claimed by many proponents of mandatory health insurance coverage for treatment of alcoholism that because alcoholics have a higher rate of illness they already use a disproportionate share of health insurance benefits. Pseudo or secondary diagnoses are said to be common practice, which means that the basic problems of alcoholism may never be acknowledged and treated. Secondly, because it is more acceptable for patients and insurers to treat the symptoms of alcoholism rather than the disease itself, statistics on alcohol-related care utilization are neither readily available nor very reliable.

Another important aspect of substance abuse as an illness is the expected success rate for treatment. In 1976 the Rand Corporation completed a study of clients at NIAAA's 44 comprehensive alcohol treatment centers. Evaluations of client samples were performed to provide a picture of alcoholics in treatment centers and to study the variables which affect successful treatment outcomes. Findings were based upon intake information and followup interviews 6 and 18 months after treatment.

The initial question which the Rand researchers faced was the definition of "success." In the alcoholism field, the meaning of "success" ranges from total abstinence to substantially improved drinking behavior. These researchers chose to use the concept of remission. Remission was comprised of three types of drinking behavior--1. abstinence for 6 months, 2. abstinence for the 1st 30 days prior to followup, and 3. normal drinking patterns. Consumption of less than 3 ounces of ethanol daily without serious levels of impairment was considered normal drinking. A control group of untreated alcoholics was

²Sidney Pell and C. A. D'Alonzo, "The Prevalence of Chronic Disease Among Problem Drinkers," Archives of Environmental Health, Vol. 16 (May, 1978), 679-684.

created by keeping data on persons initially interviewed at centers who then failed to enter treatment.

The major findings of the Rand study are as follows:

1. After the 6th and 18th month followup, approximately 70 percent of the treated clients in the sample were in remission--24 percent with 6 months abstinence, 21 percent in abstinence for the last 30 days and 22 percent in a normal drinking pattern.
2. Persons in the control group who received no treatment or very little, had a 50 percent remission rate. Formal treatment added 20 to 25 percent to the overall remission rate.
3. The differences in remission rates for various treatment types were not considered to be very large. Outcomes ranged from 56 percent remission at intermediate care facilities to 78 percent for treatment in hospitals. Outpatient treatment by itself had a remission rate of 69 percent.
4. Remission rates were no more favorable for treatment utilizing a combination of settings than for one setting. For example, hospital plus outpatient treatment yielded no better remission rates than hospitals alone.
5. The strongest negative correlate of treatment success is symptom severity--in other words, a serious alcoholic condition at intake. Instability and low socioeconomic status (SES) also contribute to negative treatment outcomes. Even so, clients with these attributes claim a 51 percent remission rate.
6. Low amounts of treatment led to significantly lower remission rates.
7. There was very little difference in remission rates for those treated by paraprofessional counselors as compared to those treated by professional therapists in outpatient settings.
8. Clients who regularly attended Alcoholics Anonymous meetings had high remission rates even when they received little or no formal treatment.
9. At the 6th and 18th month followups, relapse from remission to nonremission status was the same for normal drinkers as for abstainers (16 percent).

What, if any, application can be made of data on alcoholic clients attached to government treatment programs to alcoholics in the general population who might wish to utilize insurance benefits to treat their illness?

Rand researchers compared the characteristics of sample clients in the NIAAA programs with Harris survey data for problem drinkers in the general population and with the general population as a whole. In contrast with problem drinkers in the general population, NIAAA clients have a greater unemployment rate, are older, tend to have a larger percentage in blue collar occupations and have a median income of about half that of problem drinkers in the general population. In addition, persons entering treatment reported more severe alcohol problems.

When Harris survey problem drinkers in the general population are compared to the overall population in the same survey, it is evident that problem drinkers experience more unemployment, but not as much as alcoholics in the treatment programs. Problem drinkers are younger than the general population and constitute a lower percentage of blue collar workers. Self-reported problem drinkers have a slightly higher median household income than the general population.³ (See Appendices C and D, pages 50 and 51.)

2. Position of Employers and Insurers

How do employers and insurance specialists respond to substance abuse as an illness and to mandatory health insurance coverage as one solution to the problem? A recent survey of 20 major corporations by experts in this field reveals that all employers contacted regard alcoholism as a greater problem among employees than illicit drug use. It is speculated that alcoholism is perceived as affecting middle-aged workers at the time of greatest value to the company. Drug abuse was viewed as a problem of younger workers⁴ and also as a problem with a smaller chance for rehabilitation.

³David J. Armour, J. Michael Polich, Harriet B. Stambul. Alcoholism and Treatment. (Rand, Santa Monica, 1976), passim.

⁴H-2, Inc. "Private Industry Perspectives on Drug Abuse Treatment," reported in National Clearing House for Drug Abuse Information Report Series, Series 36, Issue C, (Spring 1977), pp. 20-26.

Insurers' attitudes about covering treatment for alcohol and drug abuse are mixed. The biggest areas of controversy seem to be not about coverage of substance abuse treatment, but coverage of treatment outside the traditional inpatient hospital modality. In addition, coverage mandated by law is certainly resisted. Among reasons cited as why third-party payers may resist coverage of substance treatment are the following:

- Other benefit programs such as dental or vision care have a higher priority among consumers.
- In nonmetropolitan areas there is less consumer interest and a lack of qualified providers.
- Third-party payers lack information needed to rate the cost of benefits. There is less cost control for treatment in nonmedical settings.
- Health care costs are already rising 14 percent a year and added benefits will drive costs even higher.
- Group members will resist sharing costs of coverage for treatment of substance abusers.
- Controversial nature of drug abuse as a disease.
- Substance abuse is considered self-inflicted and therefore, noncompensable.
- Setting of most drug treatment centers is uncomfortable to insurers. Insurers prefer traditional medical models of treatment.
- Possibility of cure and high recidivism is questioned, especially with regard to drug abusers.
- There is a reluctance to reimburse public programs which are free to some clients.
- Substance abuse beyond strictly medical care is a social problem for government, not insurance.
- At some point, paying for their own treatment has therapeutic value to substance abusers.
- State licensure or "credentialling" is not perceived to be as stringent as accreditation by the Joint Commission on Accreditation of Hospitals.

- Mandatory coverage would deter treatment development other than that specified in the law and make mandated minimum benefits the maximum.

Some insurers have taken the initiative in instituting substance abuse benefits in insurance policies and for their own employees. The Kemper Insurance Company is notable in this respect as a pioneer in the field of coverage for treatment of alcoholism. Kemper began in 1964 by removing exclusions for alcoholism from policies and by 1973 was the first insurer to provide coverage for treatment in nonhospital settings. This type of coverage was made mandatory for new policyholders. The Kemper Company states that many companies now offer some coverage but most management-labor groups don't want it. In any event, Kemper points out that the key to alcoholism recovery is an effective employee program which should then create a demand for coverage. In Kemper's own experience with employees, it is difficult to get them to utilize available insurance.⁵ Some of the other major insurance companies cited in the literature as providing coverage for substance abuse treatment are Employers Insurance of Wausau, Educators Mutual Life Insurance Company, Metropolitan Life Insurance Company and Blue Cross of Maryland, Delaware and Harrisburg, Pennsylvania. The Civilian Health and Medical Program for the Uniformed Services provides full coverage of alcoholism treatment.

To what extent do private insurers in the nation cover substance abuse treatment? A recent survey of 61 locally administered Blue Cross plans revealed that 54 of the plans cover detoxification and medical treatment. While 40 offer coverage for alcohol rehabilitation, only 33 percent cover it in a freestanding alcoholism facility. Twenty-seven and 17 percent, respectively, cover outpatient treatment in general hospitals and in freestanding facilities. Only eight plans out of 61 cover inpatient and outpatient services in both hospital and nonhospital settings. No standard benefit package exists and coverage is most comprehensive in states with legally mandated benefits. Joint Commission on Accreditation of Hospitals (JCAH) is required by 48 percent of the plans for hospital reimbursement. Thirty-eight percent of the plans require JCAH accreditation for

⁵ John Lavino, "Insurance Coverage for Alcoholism: Kemper's Experience," a paper presented at the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) Health Insurance Workshop, (San Diego, 1976).

freestanding, nonhospital treatment. This study concludes that Blue Cross plans have a nonuniform, low-level of coverage for comprehensive alcoholism rehabilitation.⁶

Another survey of insurers was completed recently in Oklahoma. Of 292 responses from insurers, approximately one-third recognized alcoholism to be a disease entity. Those which acknowledged alcoholism as a disease were then questioned further. Ninety-two percent covered inpatient emergency care for alcoholism in a hospital and 94 percent covered general hospital inpatient care.

Only one-third covered inpatient alcoholism treatment in a special alcoholism hospital. Coverage of care in intermediate care settings ranged from 2 percent in nonmedical rehabilitation centers to 40 percent in partial hospitalization settings offering day, night or weekend care. Outpatient care in a hospital setting was covered by 61 percent of the insurers, while outpatient care in mental health clinics was covered by 31 percent. Outpatient care in clinics staffed by degreed and non-degreed professionals was covered by 37 percent of the insurers questioned.

3. Nature of Treatment Programs, Staff and Clients

What response do treatment providers have to these insurance considerations? A National Institute of Drug Abuse (NIDA) survey of state drug abuse program coordinators showed that providers feel that there are tradeoffs in meeting third-party standards. It is believed that the expense of meeting these requirements may result in fiscal cuts for direct care. The survey did reveal that there is little consistency among states in such areas as credentialing and data gathering capabilities. Programs indicated that alcoholism treatment receives more support than other drug dependencies.⁸

⁶"Blue Cross Plan Alcoholism Treatment Benefits: Survey Required for Demonstrating Feasibility of Delivering an Alcohol Abuse and Alcoholism Benefit Package Through Blue Cross Plans on a Nationwide Scale." Blue Cross, 1977.

⁷Memorandum summarizing Alcohol Reimbursement Survey from Tulsa Alcoholism Advisory Committee, December 15, 1977.

⁸National Clearing House for Drug Abuse Information Report Series, Series 36B (DHEW, 1977), 1-3.

Solving the accreditation problem may be very expensive for treatment providers. According to a U.S. Department of Health, Education and Welfare report, JCAH accreditation for drug abuse treatment facilities is just beginning and is comprised of four steps which may total more than \$1,000. The process must be repeated in 2 years in an abbreviated fashion. Apparently, the reason JCAH accreditation for substance abuse facilities is so costly and lengthy is that it goes beyond program approval into service improvement.

While treatment providers favor mandatory health insurance for substance abuse treatment, they are cognizant of accreditation problems entailed by going beyond state "credentialling."

It is helpful to examine the nature of clients and staff in substance abuse programs who might be affected by health insurance coverage. In 1975, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) monitored selected programs which it funds to learn about services utilized, extent of insurance coverage and treatment outcomes. NIAAA found that 52.2 percent of clients in monitored alcohol treatment centers had no health insurance. Of those clients in alcohol treatment centers with insurance, only 20.8 percent had policies covering their alcoholism treatment. A larger percentage of participants in the monitored DUI (driving under the influence) programs had health insurance.

When NIAAA looked at types of utilization in alcohol treatment centers, it found that more clients utilized individual and outpatient counseling than any other service. The smallest utilization category was inpatient hospital care. The largest category of treatment staff is alcoholism counselors.¹⁰

A 1975 survey of alcoholism treatment centers in Oklahoma showed that nondegreed paraprofessionals constitute 57.8 percent of service providers. Physicians, psychiatrists and Ph. D. psychologists together constitute 5.4 percent of the service providers in these programs. Degreed persons in behavioral services and nonbehavioral areas and registered nurses make up one-third of the service providers in these programs.¹¹

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Ibid, Series 36A (DHEW, 1977), 17-19.

¹⁰ Evaluation Data on NIAAA Alcoholism Treatment Programs for Calendar Year 1975, NIAAA, Program Analysis and Evaluation Branch (April, 1976).

¹¹ Dick Gregory and Alfonso Parades, "Alcoholism Program Management Through the Operation of a Computerized Information System: Actuarial Data on Utilization of Services," (University of Oklahoma, 1975), Table 2.

A 1977 report by the National Institute for Drug Abuse reviews utilization of third-party reimbursement by NIDA funded drug abuse treatment centers. Third-party reimbursement included Medicaid and other public programs, as well as private health insurance. The study showed that NIDA grantees were recovering an average of 6.7 percent of their costs from third-parties and estimated that the highest amount which can be potentially recovered in this manner is 29 percent. Out of 1,600 clients in drug abuse programs with the highest rate of garnering third-party funds, only 17 percent had Medicaid coverage and only 12 percent had private health insurance. The majority of clients in these drug treatment programs were neither employed nor dependent on parents. The clients who were employed tended to be in jobs where employers did not routinely provide health insurance. The conclusion of the NIDA study was that clients in their drug abuse treatment programs are among the least likely to have third-party coverage and that most drug treatment programs cannot rely on third-party payments for their principal funds. The report does indicate that these programs¹² can improve their reimbursement rate from third-party payments.

4. Model Benefit Packages

Development of model benefit packages for health insurance coverage of substance abuse treatment is an area of considerable activity. This report reviews the national Blue Cross Association model for alcoholism treatment, the NIAAA model, the California pilot plan for alcoholism benefits and a model for drug abuse benefits.

The Blue Cross Association has contracted both with NIAAA and NIDA to develop model health insurance benefit packages for substance abuse treatment. Then field tests of the packages under controlled conditions will be conducted to generate cost data. The Blue Cross benefit package for alcoholism has been developed and will begin a 2 to 3 year field test. The drug abuse model is still in the development phase.

In developing the model benefit package for alcoholism, Blue Cross did extensive research taking into consideration such things as the clinical foundation of the disease, treatment resources, cost containment, utilization rates and market values. Their model package contains no provisions for

¹²National Institute on Drug Abuse Services Research Report, Utilization of Third-Party Payments for the Financing of Drug Abuse Treatment. (Department of Health, Education and Welfare, 1977).

inpatient treatment of the medical complications of alcoholism since they feel their policies already cover these conditions on the same basis as other illnesses. The major features of the model Blue Cross plan are outlined on the following page.

BLUE CROSS MODEL BENEFIT STRUCTURE FOR ALCOHOLISM TREATMENT

- I. Covered Settings
 - A. Intermediate Care Settings
 - B. Outpatient Care Settings
- II. Covered Services
 - A. Provider-based Medical and Psychiatric Evaluations
 - B. Room and Board
 - C. Psychotherapy (individual and group)
 - D. Counseling (individual and group)
 - E. Education
 - F. Drug Therapy
 - G. Behavior Therapy
 - H. Recreation Therapy
 - I. Family Therapy (individual and group)
 - J. Needed Drugs & Supplies Dispensed in Covered Settings
- III. Duration of Benefits
 - A. Two benefit periods of 365 days.
 - B. Benefits periods commence upon delivery of first unit of covered service. 365 days later unused benefits become void.
- IV. Amount of Benefits
 - A. Number of covered service units:
 - 1. 30 days of intermediate care.
 - 2. 30 visits of outpatient care.
 - 3. 15 visits of family therapy.
 - 4. 60 visits of outpatient care in lifetime reserve.
 - B. Level of coverage:
 - 1. Three options at choice of groups at time of enrollment:
 - a. Full Service (100% coverage)
 - b. 80-20 Coinsurance (80% coverage)
 - c. 60-40 Coinsurance (60% coverage)
- V. Other Conditions
 - A. Payment of benefits subject to physician certification of need and appropriateness within 10 days of the start of treatment.
 - B. Payment of benefits subject to Provider Eligibility Determination Protocol.
 - C. Benefits cover the employee only under an Individual Subscription and cover the employee, spouse and dependent children under Family Subscriptions.
 - D. Benefits cover eligible members whose alcoholism is an existing condition on the effective date of benefits without regard to waiting periods.
 - E. Benefits exclude payment for services and supplies that involve a duplication of any existing benefits.
 - F. Benefits provide no conversion privileges for employees and dependents separating from the group.
 - G. Benefits cover concomitant therapy for the patient's family under Family Subscriptions as well as Individual Subscriptions when the alcohol person enters treatment.

Source: Model Benefit for Alcoholism Treatment: The Foundation and Structure (January, 1977), developed by the Blue Cross Association for NIAAA.

In 1974, NIAAA developed a much less detailed model benefit package for the purpose of analyzing the range of costs for treatment in existing treatment facilities. That plan is shown below:

NIAAA MODEL BENEFIT PACKAGE FOR ALCOHOLISM TREATMENT

Inpatient Emergency Care - 6 days

- . General Hospital
- . Specialized Alcoholism Hospital
- . Other Specialized Hospitals
- . Hospital-Affiliated Medical Emergency Care Center
- . Hospital-Affiliated Non-Medical Emergency Care Center

Inpatient Care - 14 days

- . General Hospital
- . Specialized Alcoholism Hospital
- . Other Specialized Hospitals
- . Hospital-Affiliated Inpatient Care Facilities Under Medical Supervision

Intermediate Care

- . Partial Hospitalization in the Form of Day, Night, Evening, or Weekend Care - 28 days
- . Specialized Alcoholism Hospital - 28 days
- . Recovery Home/Halfway House - 60 days
- . Other 24-Hour Residential Rehabilitation Center of an Essentially Non-Medical Nature - 28 days

Outpatient Care - 45 days

- . Hospital-Based Outpatient Clinic
- . Community Mental Health Center or Freestanding Clinic Staffed by Degreed and Non-Degreed Professionals
- . A Family or Neighborhood Alcoholism Health, Mental Health, or Social Service Center Typically Staffed by Non-Degreed Professionals

Source: Model Benefit Costs in Alcohol Treatment Programs (March, 1974) unpublished for NIAAA.

In 1974 California, in response to a legislative mandate, developed a 2-year pilot program for public employees to test the feasibility of providing model health insurance coverage for alcoholism treatment. The schedule below reflects the benefit structure of the pilot program.

CALIFORNIA PILOT PROGRAM
SERVICE/INDEMNITY HEALTH PLANS
SCHEDULE OF BENEFITS

The following benefits will be provided to eligible health benefits plan members for the treatment of alcoholism as a primary diagnosis condition. The maximum stated benefit per year is available to each eligible member.

INPATIENT CARE: In a facility (medical and/or nonmedical) licensed or certified by the State of California.

- a. Acute: Pays in full for up to 6 days of detoxification - Up to a maximum per day of.....\$ 160.00
Maximum benefit per covered person not to exceed..... 960.00
- b. Intermediate: Pays in full for up to 21 days of treatment - Up to a maximum per day of..... 100.00
Maximum benefit per covered person not to exceed..... 2,100.00
- c. Ambulance service not to exceed..... 50.00
per person for emergency transportation to obtain detoxification services.

DAY AND/OR NIGHT CONTROLLED RESIDENTIAL CARE: In a recovery home licensed or certified by the State of California.

Pays in full for up to 30 days -
Up to a maximum per day of.....\$ 15.00
Maximum benefit per covered person not to exceed..... 450.00

OUTPATIENT CARE:

Up to 45 visits per covered person*
Up to a maximum per visit of\$ 25.00
Maximum benefit per covered person not
to exceed..... 1,125.00

To be provided by a:

- a. Licensed physician: (M.D. or D.O.)
- b. Licensed marriage, family and child counselor
- c. Licensed clinical social worker
- d. Licensed psychologist
- e. Paraprofessional provider identified, or the appropriate agency of the State of California, to provide services for the treatment and care of alcoholism.

*Up to 10 outpatient visits per person per year can be utilized on an "inpatient" basis upon appropriate verification of need.

EXCLUSIONS AND LIMITATION:

Outpatient family counseling visits will be limited to 5 visits pending the actual diagnosis of "alcoholism" for the noncounseled person.

Source: A Pilot Program Providing a Broad Range of Service for the Care and Treatment of Alcoholism (July, 1974), California Public Employees Retirement System.

In addition to model benefit packages for treatment of alcoholism, at least one model has been formulated for drug abuse treatment. It's major points are described below.

MODEL HEALTH INSURANCE BENEFIT
PLAN FOR THE TREATMENT OF DRUG ABUSE

<u>Treatment Benefits</u>	<u>Limit of Stay per year</u>	<u>Other Conditions</u>
<u>A. Inpatient:</u>		
Room & Board	7 days per sequence x 3 admissions =	State accredited or licensed hospi- tal or inpatient treatment facility.
Medical Services & Supplies	21 days	
X-ray and lab		
Medicines & drugs		
<u>B. Intermediate:</u>		
Room & Board	60 days per sequence x 3 admissions =	State licensed intermediate treat- ment facilities including therapeutic communities, halfway houses, day care centers, special ethanol treatment centers, day or night hospitals.
Professional Treatment Services	180 days	
Testing Services		
Medicines & drugs		
<u>C. Outpatient:</u>		
Counseling & Therapy	45 visits per benefit period for counseling purposes	State licensed treatment facility with outpatient capability, including methadone treatment centers.
Costs of all drugs for methadone maintenance		

OTHER PROVISIONS:

1. Extensions of original treatment periods are subject to facility professionals.
2. No limit of times a person may enter a treatment sequence.
3. No reimbursement incentives against persons failing to complete treatment sequence.
4. Coinsurance and deductible left to insurance carriers.

Source: Jerome B. Hallan, Harold D. Holder, Martha J. Stucker and Linda Latta. "Model Health Insurance Benefit Plan for the Treatment of Drug Abuse." H-2 Inc. (Cary, N.C., 1975).

5. Cost Reports

Precise fiscal data on the costs which are attributable to insurance coverage of alcoholism and drug abuse are extremely difficult to locate. One reason is that even companies which cover these illnesses do not keep separate records on any single component of their medical payments experience. There are numerous factors which will affect the quantity and costs of substance abuse health benefits. Therefore, even where cost estimates are available, they may not be applicable to plans with different benefit limitations, different kinds and number of populations and so forth.

Some of the factors which influence the quantity and costs of substance abuse treatment are:

- Internal motivation, personal characteristics
- Role of employers
- Outreach provisions
- Early detection
- Chronicity of disease
- Extent of disease among covered group
- Inflation
- Efficient management policies
- Cost containment measures
- Demand for services in relation to supply
- Tradeoffs in utilization of benefits for other illnesses
- Geographical location of treatment facilities

The lack of reliable cost data was an impetus for the Blue Cross Association to develop its own model benefit package for alcoholism coverage and to field test it to gain sufficient underwriting experience to determine the risks involved. The Blue Cross study will evaluate the feasibility of establishing outpatient benefits for alcoholism treatment in all Blue Cross policies. Similar Blue Cross efforts are underway for drug abuse coverage. For the purpose of field testing the model alcoholism benefit, Blue Cross developed a rate

equation based on overall utilization by policyholders and type and amount of services as seen in selected existing programs.

Assuming the full model benefits are used (30 days intermediate care, 30 visits outpatient care and 15 family visits), a utilization rate of .4 of 1 percent, and assuming costs of \$65 per day for intermediate care and \$30 per visit for all outpatient care, Blue Cross developed a pure premium cost for treatment of \$7.74 per year for individual subscribers or 65 cents a month. This is a pure premium estimate which does not include a loading factor for administrative costs nor coinsurance options.

Blue Cross recognizes that existing underwriting experience is inadequate for prediction purposes and, therefore,¹³ plans to revise premium charges to reflect field test data.

There are a few reports available which measure and predict costs of health insurance coverage of substance abuse. Careful records were kept for the recent California pilot plan which, as mentioned previously, provided health insurance coverage for inpatient and outpatient alcoholism care for public employees.¹⁴ The pilot program lasted 23 months from June 1974 to May 1976. Day to day administration of alcoholism treatment benefits was handled by the Public Employees Retirement System (PERS) which normally manages insurance programs for public employees. Nine different health insurers were involved in the program. Because of the pilot nature of the plan, all costs were paid out of a state general fund appropriation of slightly over \$675,000. Funds were allowed for benefits and for carrier and PERS administrative expenses.

Utilization of alcoholism treatment benefits was quite low. Only 766 persons were treated out of 140,757 basic plan enrollments for a utilization rate of 0.5 percent. The ratio of males to females utilizing alcoholism treatment benefits was 69 percent male to 31 percent female. Average age for alcoholism beneficiaries was 46.9. Of the 766 persons treated, 542 persons received outpatient care, 339 inpatient care and 15 persons had recovery home stays.

¹³ Blue Cross Association, "Rate Equation Development" unpublished paper attached to Model Benefit for Alcoholism Treatment: The Foundation and Structure (January 1977).

¹⁴ Robert W. Wilson, Martin Green and Florence Beller, Health Benefits Division, California State Public Employees Retirement System, "Alcohol Pilot Program, July 1974 - May 1976, Final Report," passim.

Because inpatient care is more expensive than other types of care, inpatient benefits accounted for 86.7 percent of treatment costs, while outpatient care comprised only 12.3 percent of total treatment costs. Average cost per day for all inpatient care was \$123.21 and average inpatient cost per person for the program was \$1,732. For inpatient treatment, general hospitals accounted for 37.8 percent of all admissions, followed by alcohol units in hospitals with 34.8 percent of all alcoholism admissions and alcohol hospitals with 20.6 percent of all admissions. Costs per day were highest in general hospitals, but because of length of stay, alcohol units in hospitals account for 50.6 percent of inpatient care costs.

Outpatient utilization in the California program was the category of treatment most used with 542 persons making 5,028 outpatient benefits. The average cost per outpatient benefit was \$16.57. Cost per visit varied from \$4.11 for paraprofessionals to \$21.12 for a psychologist to \$25.86 for licensed counselors. Beneficiaries utilized physicians for outpatient visits 44.1 percent of the time and paraprofessionals 39.2 percent of the time. Average outpatient cost per person in the program was \$153.15. Finally, it should be noted that the California pilot program experienced a total cost per person of \$885.¹⁵

Based on the program's 23 months of experience average premium costs of 17 cents per month or \$2.05 annually per policy would have been necessary to cover costs of care of alcoholism treatment.¹⁶ One analysis of costs of alcoholism coverage versus savings indicates that for each \$1 spent on treatment in the pilot program, 42 cents was saved in costs for other health treatment.¹⁷ (See Appendix E, page 52 for data on the California pilot program.)

Another cost study was performed by Booz, Allen and Hamilton in 1973 in an attempt to estimate the costs of NIAAA's model

¹⁵Ibid.

¹⁶Harold D. Holder and Jerome Hallan, "A Study of Health Insurance Coverage for Alcoholism for California State Employees" (Raleigh, N.C. 1976), p. 9.

¹⁷Ibid, p. 13.

benefit package for alcoholism treatment.¹⁸ Site visits were made to 30 programs with 63 different treatment settings. Although the actual cost figures of the 1973 study are somewhat out-of-date, the information is still valid for comparing relative costs of treatment. Cost-per-client-stay for regular inpatient care was found to be most expensive at hospital affiliated centers with medical supervision and least expensive at specialized alcoholism hospitals. Cost-per-client-stay for intermediate inpatient care was greatest in the partial hospitalization setting and least expensive in recovery homes. Cost-per-client-stay for outpatient treatment was most expensive at community mental health centers and least expensive at hospital based outpatient facilities.

(See Appendix F, page 53 for charts comparing costs of type of facility.)

Finally, potential costs for drug abuse coverage were developed from actual costs from a variety of reports by Hallan *et al* for the model drug abuse health insurance benefit plan. Depending on whether clients utilize from one-half to the full benefit days allowed, inpatient treatment under the model benefit was estimated to range from \$1,040 to \$2,184 per benefit period (10-21 days) and intermediate care was predicted to go from \$2,160 to \$4,320 (90-180 days). Outpatient costs for drug abuse treatment for a single benefit period was estimated to range from \$594 to \$1,215 per person (22-45 visits). (See Appendix G, page 54.) These estimates may be compared to actual cost figures as found by NIDA in a sample of 22 drug treatment programs. In that study, average cost for a residential treatment episode was \$1,847 for an average stay of 2.8 months. Average cost for an outpatient methadone treatment episode was \$747 for an average period of 4.1 months. Outpatient drug-free treatment sustained an average cost of \$368 for a treatment period averaging 2.8 months.¹⁹

¹⁸ Booz, Allen and Hamilton, Model Benefits Costs in Alcoholism Treatment Programs, Report for NIAAA (1974), p. 13.

¹⁹ National Institute on Drug Abuse Services Research Report, Utilization of Third-Party Payments for the Financing of Drug Abuse Treatment, (DHEW publication, 1977), p. 11.

B. SURVEY OF THE STATES

Staff for the subcommittee surveyed the 50 states in 1977 to ascertain which of them mandated health insurance coverage for treatment of alcohol and drug abuse, what types of policies are affected, what benefits are provided and whether or not fiscal impact information is available. (See Appendix H, page 55.) Of the 42 states responding, 14 mandate insurance coverage for treatment of alcohol abuse and five mandate coverage of drug abuse. In addition, 10 responding states require that certain insurance policies offer coverage for mental disorders and for alcoholism, at the policyholder's option. States which mandate health insurance coverage of alcoholism are as follows:

Connecticut	Mississippi	Oregon
Hawaii	Missouri	Virginia
Illinois	New Jersey	Washington
Massachusetts	North Dakota	Wisconsin
Minnesota	Ohio	

States requiring health insurance coverage of drug abuse are listed below.

Hawaii	North Dakota	Wisconsin
Minnesota	Virginia	

Among the mandatory states, a wide variety of benefits is offered. Most states with laws mandating coverage for alcoholism limit the requirement to group policies. Three states extend the requirement for mandatory coverage to individual as well as group policies.

Benefits vary considerably in states with mandatory health insurance coverage of substance abuse. Usual categories of benefit limitation are inpatient versus outpatient care, type of facility, duration of treatment and dollar limitations. All 14 states with mandatory legislation cover inpatient care and seven of them require coverage of both inpatient and outpatient care. Similarly, several states specify that treatment must take place in licensed health care facilities. No state law required Joint Commission on Accreditation of Hospitals (JCAH) approval as the sole criterion for insurance reimbursement, although a few mentioned that JCAH approval indicates an acceptable facility or that standards must be equivalent to those of JCAH. Ohio requires that treatment be provided by or under the supervision of a licensed physician or psychologist. Limitations on length of treatment were specified in seven

states and ranged from 28 residential days per year in Minnesota to 70 hospital days in Hawaii. Outpatient or partial hospitalization limits varied from 140 days in North Dakota (which count toward hospital day limits as well) to 130 hours a year in Minnesota.

Dollar limitations were found in four states and were \$500 per year for outpatient visits in Massachusetts, \$1,000 per year for inpatient care in Mississippi, \$3,000 per 24 months for all types of care in Oregon and \$500 per year in Ohio.

The final question asked of other states concerned the fiscal impact of requiring health insurance coverage for substance abuse. Only one of the 14 states with mandatory coverage could provide any fiscal information either for costs projections at the time of the legislative enactment or later data based on actual experience. The Blue Cross plan for Wisconsin filed a group premium rate increase of 69 cents per month for the individuals and \$1.99 per month for families, pursuant to the 1975 requirement for coverage of outpatient treatment of alcoholism and kidney disease. These rates were accepted with the understanding that they would be reviewed in light of later experience.

Most states responded that they had no fiscal impact information and that the laws were too new for the state to produce data based on experience. Colorado, which has a law requiring insurers to offer purchasers the option of policy provisions covering the treatment of alcoholism, also supplied cost figures from Blue Cross/Blue Shield. The Colorado Blues indicate that extending group alcoholism coverage from 30 to 45 hospital days resulted in an annual premium increase of \$3 for individuals and \$6.72 for families. No costs were stated for the original 30 days of hospitalization.

C. SURVEY OF INSURANCE COMMISSIONS

In January of 1978, the Nevada insurance division surveyed insurance commissions in states which mandate health insurance coverage for substance abuse. Questions were asked concerning claims and cost experiences for the mandated benefit and opinions on the laws requiring such coverage. Only four meaningful responses were received and they were from New Jersey, Hawaii, Illinois and Minnesota. None of these states had compiled cost data based on claims experience. Minnesota reported that the insurance industry estimated a cost of 15 cents for individuals and 35 cents for families covered by group policies for residential substance abuse treatment, with the cost for 130 hours of outpatient treatment approximately .5 percent of the hospital rate.

The few insurance commissions replying apparently were satisfied with laws mandating coverage. New Jersey's insurance commission stated that it was unlikely that absence of third-party payment in the past had been a major factor in alcoholics failing to seek treatment, but that availability of coverage should contribute to the effort to control the state's alcoholism rate.

On the basis of the few responses received and the lack of responses from most states, the Nevada insurance division concludes that it is probable that none of the states with laws mandating insurance coverage of substance abuse looked to the long range impacts before implementing the mandate. In summary, the insurance division indicates that none of its efforts nor those of the subcommittee have generated adequate cost data. Further, a spokesman for the insurance division informed the oversight subcommittee that even if information were available from other states, it would not provide adequate information for Nevada since benefits and other variables are unique to each state. The insurance division recommends that coverage be limited to group policies to spread and minimize costs and that a task force be formed between the time the law is enacted and when it becomes effective to develop realistic dollar benefit levels based upon care costs in Nevada.

D. SURVEY OF NEVADA HEALTH INSURERS

In May of 1978, a joint survey of 10 large health insurers in Nevada was conducted by subcommittee staff and the Nevada insurance division. Insurers contacted were Prudential, Combined Insurance, Cal-Western Life Insurance, Mutual of Omaha, Guardian Life, Connecticut General Life, Occidental, New York Life, CNA and Crown Life. As of late June 1978, seven companies had responded excluding Guardian Life, Connecticut General and CNA. One company did not cover group hospital or medical expenses so responses represent only six companies. Insurers were asked for information about present coverage of substance abuse and premium rates attributable to such coverage. Insurers' opinions on mandatory health insurance coverage for substance abuse treatment were also solicited. Following is a summary of responses to major questions.

1. Do you sell health insurance in states which require health insurance to cover treatment for alcoholism and drug abuse? All six companies replied "yes."
2. What does your company add as premium charge to a policy, group or individual, by state for coverage of treatment of alcoholism and/or substance abuse? Of the six companies

responding, two answered that when alcoholism and drug abuse are not distinguished from other illnesses in terms of coverage, there are no specific charges attributed to them in premiums. They indicated that when mandated benefits are provided on a more favorable basis than for other illnesses, incremental (unspecified) charges in premiums may be made in some states. One company stated that it has never studied specific costs. The remaining three companies provided premium estimates which ranged from 30 cents per month per family for alcoholism in group policies to no premium charge by a company providing only 30 days of hospital inpatient coverage in individual policies, to \$20 per month for an individual adult policy covering 30 days every 6 months in an alcoholism treatment facility.

Variations in Premiums	<u>Estimated Premium Costs</u>	<u>Coverage</u>
	Group	
	1. \$.30/mo. per family	Alcoholism. All states where provide on same basis as other illnesses.
	2. \$.50/mo. per employee \$.75/mo. for dependents	Benefits as mandated where sold.
	3. \$.0/mo. \$.79/mo.	Inpatient + general hospital and Inpatient in nonhospital (30 days) plus Outpatient as option in Nevada of 180 days or \$800.
	4. \$.45 to \$.85/mo. per person	Same as other illnesses but liberal hospital definition to recognize certain treatment facilities as required.

Premiums costs and coverage in individual policies varied tremendously among the insurers responding and for one insurer, premium costs from that company alone ranged from no premium addition in Virginia, where coverage is limited to 30 days hospital confinement, to an estimated \$20 per month in South Dakota which allows 30 days in an alcohol treatment facility per 6 months. That same company estimates that the Nevada individual major medical policy option (10 hospital days, 30 other facility inpatient days and 180 outpatient days up to \$800 per year) would cost \$11 per month premium. It should be noted that several companies cover substance abuse treatment for children under 20 at lower rates than for adults.

3. If you provide both inpatient and outpatient substance abuse benefits, what is the premium cost attributed to each? None of the responding companies could provide a breakout of premium charges on this basis. Interestingly, in the one policy copy provided, "hospital" was narrowly defined as a facility with major surgical facilities and allowable outpatient treatment included such items as physicians visits and accidental injuries. Responses to other questions indicated a reluctance to cover treatment in nonhospital facilities. Two insurance companies took a more liberal view of appropriate inpatient treatment setting.
4. What are the substance abuse benefits which your company offers by state? Most of the responses to this question were not specific and declared that the benefits were the same as for other illnesses. All companies said that where state law so required, specified and usually greater benefits are provided. One company stated that with the exception of two states, substance abuse treatment is subject to a lifetime maximum.
5. Do any of your group policies for Nevada specifically exclude coverage of alcohol and drug abuse? How is such coverage limited?
 - a. One company formerly excluded institutions used principally as facilities for care of drug addicts or alcoholics as coming under the definition of hospital. It declared that since 1972 their group policies have eliminated the exclusion for alcoholism and have done the same for drug abuse in group policies since 1973. A 1974 copy of an individual policy from that company excludes drug addiction facilities from the definition of hospital.

- b. Another company excludes treatment for alcoholism treatment in a hospital which is not a general hospital. Existing policies from that company exclude treatment of narcoticism or addiction to other habit forming drugs.
- c. One company indicated that its only Nevada group policy excludes treatment for alcoholism from both the basic and major medical parts of the contract.

The three remaining insurance companies indicated that their policies carried no such exclusions, unless a policyholder were to specifically request an exclusion.

- 6. Do you provide group coverage in Nevada for inpatient and outpatient treatment of alcohol and drug abuse? Several insurers answered that group policies cover substance abuse on the same inpatient-outpatient basis as other illnesses. One of these companies specifically qualified outpatient care as general hospital outpatient care. Four insurers mentioned that these benefits were made available as set forth in 689B.037. One insurer stated that treatment by nonmedical personnel (social workers, ex-addicts) in non-recognized facilities (drug or alcohol rehabilitation centers) is not covered unless mandated by the state. Still another company declared that allowable outpatient services, other than those for other illnesses, included psychiatric treatment on a 50 percent copayment basis per first \$30 of charges per treatment up to five treatments per year.
- 7. What is your present experience in Nevada with regard to claims attributed to alcoholism and drug abuse? Five of the respondents indicated that there is insufficient data on the subject and that no records are kept separating insurance experience for substance abuse from all other illnesses. One company also pointed out that it has no policies in Nevada which cover substance abuse.
- 8. Do you favor mandatory coverage in group policies of substance treatment? Why or why not? As would be expected, all six companies responded "no." Reasons given for opposing this legislation are:
 - Opposed to special benefits for any illness.
 - Favor freedom of contract.
 - Feel that effects of substance abuse not a concern to

most of the insurance buying public.

- Could cause reduction in amount of other coverage.
 - Should be choice of employer.
 - Coverage is always available on request.
 - Would contribute to rising insurance costs.
 - Could be expensive and never lead to improvement.
9. If such legislation were recommended, do you have any suggestions concerning its provisions? Only three companies presented ideas in response to this question. One company suggested that the law simply require substance abuse to be treated as any other illness. Another company declared that any requirements should be limited to hospital inpatient coverage. A final suggestion was that states which legislate in this area should attempt to achieve uniformity.
10. What would be the impact of mandatory coverage on policy structure and indirect costs? One company pointed out that mandated coverage does not fit an insurer's standard policy structure and therefore, would destroy uniformity of benefits provided by one company in all the states. Indirect costs such as costs for reprinting policies and brochures and costs for training and administration of nonstandard provisions were mentioned also. Several companies declared that indirect costs depended on the nature of the coverage mandated. One company stated that for individual policies, charges for new policies could be added by rider, with very low indirect costs.

While the survey did not provide definitive cost data for Nevada should it mandate health insurers to cover substance abuse, it did bring out several important points. Most, not all, Nevada health insurers in the survey do not claim to oppose regular hospital care of substance abusers. The major objection appears to be the setting of treatment, with general hospitals acceptable for inpatient care, but not specialized alcohol hospitals or inpatient facilities in most cases. Outpatient care under provisions "the same as all other illness" does not appear to encompass the kind of outpatient treatment usually provided for substance abusers (therapy, counseling, etc.).

Premium costs and coverage varied widely. Group and individual premiums generally were not rated on a state-by-state basis. There was a general indication that the more benefits vary from standard coverage, the greater the premium. Premium costs for individual policies for substance abuse coverage were estimated much higher than group rates. These estimates apparently are not predicted upon actual cost experience since no companies kept segregated statistics for substance abuse. Another point is that exclusions for substance abuse coverage do exist in insurance policies even though such coverage must be offered. The final point gleaned from the survey is that the large health insurers in Nevada very definitely oppose legislation in this area.

E. ALCOHOLISM AND DRUG ABUSE IN NEVADA

1. The Problem

Alcoholism, problem drinking and substance abuse have been defined in many various ways. One common way of defining problem drinking is to list symptoms. The problem with lists of this nature is that they are not particularly consistent and vary among authors. Another way of identifying alcoholism is to describe alcoholics. A common misconception is that most alcoholics are skid row bums. National estimates indicated that only 3 to 5 percent of alcoholics fit this stereotype. Section 458.010 of the Nevada Revised Statutes defines an alcohol and drug abuser as "as person whose consumption of alcohol or other drugs, or any combination thereof, interferes with or adversely affects his ability to function socially or economically." An alcoholic is defined by the same NRS section as "any person who habitually uses alcoholic beverages to the extent that he endangers the health, safety or welfare of himself or any other person or group of persons."

It is somewhat easier to discuss the magnitude of substance abuse than it is to define it. The Nevada state plan for the bureau of alcohol and drug abuse estimates the alcoholism rate for Nevada to be 6.7 percent or greater than 29,000 persons. (See Appendix I, page 62.)

The formula used to arrive at this figure is tied to deaths caused by cirrhosis of the liver and is thus considered more reliable and reflective of resident population than rates based on alcohol consumption. The 6.7 percent alcoholic rate is believed to be quite a conservative figure since it accounts only for alcoholics 15 years of age or older. Treatment utilization reports indicate that Nevada substance abuse programs see

less than 6 percent of the alcoholic population in the state.²⁰ Of those alcoholics who are treated in Nevada facilities, client data indicate that most are white males over 40. Two-thirds of those treated are unemployed and 40 percent have received prior treatment. (See Appendix J, page 63, for profile of alcohol abusers in treatment.)

Reliable estimates of drug abuse in Nevada are unavailable since there are few diseases which correlate so closely with drug abuse as liver cirrhosis does with alcohol. A 1974 survey by the state rehabilitation division estimates that 3.1 percent of Nevada's population or 10,726 persons use opiates and dangerous drugs. (See Appendix K, page 64.)

Opiates include heroin, morphine and other opiates. Dangerous drugs include LSD, barbiturates, amphetamines, etc. Because of the self-reporting nature of surveys, some experts indicate that surveys underestimate actual drug abuse rates.²¹ Even so Nevada ranks third in the nation for heroin addicts.²¹ According to the bureau of alcohol and drug abuse, Nevada has a very high drug use risk because of its degree of urbanization, large percentage of young males, transient population, easy access to drugs and existing alcohol abuse. A profile of Nevada's drug abusers indicates that they are young (14-25), male and living in an urban setting.²² Of those drug abusers in Nevada treatment centers, the primary drug problem is opiates followed by barbiturates. With the exception of opiate users, most hard drug users in treatment programs are poly drug users.²³ Unemployment rates of drug users in Nevada treatment programs range from 70 to 93 percent. (See Appendix L, page 65, for profile of drug abusers in treatment.)

According to the Nevada state substance abuse plan, treatment success for drug abusers as measured by program completion ranges from a zero rate for barbiturate users to the highest rate of 34.5 percent for users of amphetamines. (See Appendix M, page 66.)

²⁰ Bureau of Alcohol and Drug Abuse. The Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse 1977-78, (Carson City, 1977), p. 13.

²¹ Bureau of Alcohol and Drug Abuse, Op. Cit., p. 30.

²² Ibid.

²³ Ibid, p. 18.

Another indicator of substance abuse in Nevada is criminal justice data. According to data extracted by the state bureau of alcohol and drug abuse from Federal Bureau of Investigation Uniform Crime Reports, drug and alcohol related arrests in Nevada in 1977 totalled 3,595 for drug sales, manufacturing or possession, 2,271 for violation of liquor laws, 14,704 for civil protective custody and 6,435 for DUI. These 1977 figures represent an increase in arrests from 1976 of 27 percent for liquor violations, 22 percent for civil protective custody and 8 percent²⁴ for DUI. Arrests for drug violations decreased by 7 percent.

2. Existing Resources

The 1977 legislature appropriated \$684,633 of general fund money for alcohol and drug abuse programs in Nevada for 1977-78 and \$763,111 for 1978-79. The addition of federal funds brings Nevada's budget for substance abuse programs to almost \$2 million for 1977-78 and approximately \$1.5 million for 1978-79. With these resources, the state bureau of alcohol and drug abuse (BADA) funds 31 programs serving an estimated client population of 4,120. Alcohol detoxification accounts for 2,000 clients with 2,120 persons in all other programs. BADA funds 12 drug programs, 10 alcohol programs and nine other programs which serve both categories. (See Appendix N, page 67.)

BADA clients are 79 percent outpatient and 21 percent residential, exclusive of two social detoxification programs. Cost of residential treatment in BADA programs ranges from approximately \$25 per day for 90 days in a halfway house to \$50 per day for a two-week residential program for alcoholics. Outpatient counseling, which may last from 3 to 6 months, costs from \$15 weekly for group counseling to \$45 weekly for individual counseling. Social detoxification costs approximately \$30 per day and averages 3 1/2 days.

According to the bureau of alcohol and drug abuse, out of all BADA clients (except detoxification clients), 72 percent have no health insurance. Approximately 21 percent have private health insurance and another 4 percent are covered by public funds or public insurance. (See Appendix O, page 68.)

²⁴Bureau of Alcohol and Drug Abuse, "Alcohol/Drug Abuse Indicators," unpublished paper (Carson City, July, 1977).

In addition to BADA funded programs, there are at least 19 other public and private substance abuse programs in Nevada. There are four hospitals including the Nevada mental health institute, six residential centers and nine outpatient clinics including the Clark County health district methadone clinic, two intertribal councils on alcoholism and the Nellis Air Force Base drug and alcohol program. (See Appendix N, page 67.)

Still another resource for problem drinkers in Nevada is a program for persons convicted of driving under the influence. Nevada's office of traffic safety reports that there are DUI education programs in Reno, Las Vegas, Carson City, Hawthorne, Yerington, Fallon, Lovelock, Winnemucca, Elko and Ely. These schools represent an alternative to traditional sentencing. Statistics show that in 1976, 42 percent of all drivers and pedestrians involved in Nevada traffic fatalities had been drinking. (See Appendix P, page 69.)

3. The Nevada Credentialling Model

One consideration in determining the feasibility of requiring health insurers to cover treatment of substance abuse is the quality of programs which would receive private third-party payments. In Nevada the primary method of establishing substance abuse treatment standards is "credentialling." Nevada Revised Statutes 458.025 requires the state bureau of alcohol and drug abuse to develop program standards and provide for fund withdrawal from programs which fail to meet those standards. "Credentialling" consists of certifying personnel, accrediting programs and licensing facilities. Personnel must be certified before a program can be accredited and programs must be accredited before facilities can be licensed.

Certification of substance abuse counselors and program administrators is the responsibility of the BADA board of certification. Minimally the board consists of one drug abuse counselor, one alcoholism counselor, one licensed psychologist, one educator and one BADA representative. The board sets certification requirements and administers exams. All paid substance abuse counselors and administrators must be certified. Experience requirements for certification are:

- A graduate degree in specified social science areas;
or
- A bachelors degree in specified social science areas plus 2 years paid professional counseling work;
or

- Five years paid professional counseling experience

The board appears to have considerable flexibility in setting experience qualifications since it may authorize substitution of special substance abuse training for experience and consider voluntary experience. "* * * Demonstrated successful experience will be given preference over education alone."²⁵

In addition to experience requirements, BADA's certification board requires an examination which may be written or oral or both and covers such things as general knowledge of drug and alcohol information, treatment techniques and planning, symptomology, diagnosis and referral, followup care and crisis intervention. Program administrators are required additionally to be familiar with general administrative techniques including fiscal management.

No abuse of controlled substances is permitted for 2 years prior to application. Persons who fail to meet certification standards may be given provisional certification for up to 3 years at the board's discretion.

Program accreditation is the responsibility of BADA, although the guidelines are developed cooperatively with the bureau of health facilities which establishes the appropriate regulations. Included in program accreditation requirements are:

- Written guidelines for client services.
- BADA review of utilization, admission criteria etc.
- Internal evaluations.
- Clear governing body authority and duties, including written review of standards of service, budget review, provisions for client transfer, client rights, client funds, provisions for disaster plan and liability insurance.
- Certified staff - If an inpatient facility -- 24

²⁵ Bureau of Alcohol and Drug Abuse. Credentialling Model for Substance Abuse Personnel, Programs & Facilities (Carson City), p. 4.

hour registered nurse. If detoxification facility --
24 hour licensed nurse with an R.N. supervisor.

- Requirements for client records.
- Needs assessment program.
- Availability of training.
- Community education.
- Activities program.

Program accreditation is for 1 year and provisional status may be given for 6 months.

Facility licensure is performed by the state board of health which conducts prelicensure surveys of facility applicants and programs. Included in facility licensure requirements are:

- Facility ownership disclosure.
- Character references for applicants.
- Compliance with life safety, environmental health, building and zoning codes.
- Program accreditation and personnel certification.
- Provisions for governing body, goals, etc.
- Financial requirements - resources to operate 120 days.
- Protection for clients (rights, funds, etc.).
- Medical requirements (e.g., administering drugs, physical exams, etc.).
- Pharmaceutical service requirements.
- Dietetic service provisions in residential facility.

Facility licensure is in effect for 1 year and a provisional license may be issued for 1 year. Authorized complaints about substance abuse facilities must be followed by unannounced visits by the division of health.

4. General Needs Presented to the Oversight Subcommittee

Although Nevada is meeting some of its substance abuse problems

through programs funded by the state bureau of alcohol and drug abuse, in the course of its public hearings and facility tours, the oversight subcommittee heard statements about additional, unmet needs. The following list presents some of these needs:

- Additional funds for direct substance abuse services.
- More outreach activities.
- Child care centers for children with parents in rehabilitation.
- Increased public awareness of the problem.
- Employer programs for substance abuse treatment - state employment security department estimates that 16,500 persons in the Nevada labor force have substance abuse problems. The occupational assistance program for the state indicates that of the state employees seen since late 1973, 50 percent involved alcohol or drug abuse problems.
- More accountability for students and parents of abusers - Spokesman for one school district suggested that names of students caught abusing alcohol and drugs should be printed in the newspaper and that school districts and law enforcers should be permitted to exchange information about students. Bureau of alcohol and drug abuse estimates that 75 percent of Nevada's high school students are using alcohol.
- More attention to the low profile, female alcoholic - Bureau of alcohol and drug abuse estimates that there are 6,000 women alcoholics in Nevada.
- Shortage of detoxification centers except for regular hospitals - For example, the only social detoxification center in Reno is limited to civil protective custody clients (CPC).
- Need for adolescent residential substance abuse centers - Currently youths are sent to correctional centers at Caliente and Elko which are not geared to substance abuse treatment and are expensive.
- More training for treatment personnel - Some persons coming before the subcommittee felt that counselors

with a background of alcohol abuse and recovery made effective counselors. A Nevada municipal judge stated that completion of an Alcoholics Anonymous program does not qualify a person as a substance abuse counselor and recommends that counselors have formal education with state certification.

5. Statements to the Subcommittee on Mandatory Health Insurance

In addition to learning about the general problems and treatment of alcoholism and drug abuse, the subcommittee concentrated its attention on the question of whether or not to require health insurers to cover substance abuse in insurance policies.

Statements to the subcommittee were generally divided between providers of treatment who favor mandatory coverage and insurance representatives who took the opposite point of view. A strong proponent of mandatory coverage of substance abuse treatment was the director of the Fallon New Frontier Treatment Center (NFTC). The New Frontier Treatment Center deals primarily with alcoholics and presently has the capacity to treat about 336 persons a year. Treatment costs \$700 for 2 weeks, and approximately one-third of NFTC's expenses are covered from third-party payments. If success is described as soberness or substantially improved drinking behavior, NFTC boasts a recovery rate of 62 percent. Clients are not accepted twice for this program. According to NFTC's spokesman, one of the reasons Nevada began certifying counselors and accrediting programs was the argument from insurers that mandatory insurance coverage was impossible without program accountability. Now that Nevada has a "credentialling" program, NFTC feels that health insurance should be required to cover substance abuse treatment.²⁶

Another supporter of legislation mandating health insurance coverage for substance abuse was a member of the Reno alcohol and drug abuse advisory board who cited the need for treatment services for the alcoholic's family. Also favoring mandatory coverage of health insurance was the state personnel division's occupational assistance spokesman who stated that without state insurance many persons would not be able to obtain treatment

²⁶ Statement to the Legislative Commission's Oversight Subcommittee to Study the Problems and Treatment of Alcoholism and Drug Abuse, November 4 tour of facilities, Fallon.

for substance abuse.²⁷ A director of a social detoxification program told the subcommittee that any program certified by BADA and licensed by the state should qualify for insurance reimbursement. He emphasized strongly that successful recovery depends on followup care after detoxification.²⁸ The subcommittee learned from the alcohol care unit in the North Las Vegas Hospital that Aetna Insurance Company requires participation in a followup care program prior to reimbursement. While this practice created a cash flow problem for the hospital, it was believed to improve chances for recuperation. Treatment at the North Las Vegas unit costs \$150 per day for detoxification and \$100 per day thereafter. Ninety-two percent²⁹ of the patients at that facility have some form of insurance.

Raleigh Hills Hospital, a special alcoholism treatment facility, was a strong advocate of mandatory health insurance coverage for alcoholism treatment. Care at Raleigh Hills costs \$220 per day for detoxification and \$110 per day thereafter. Private insurance pays for 52 percent of their inpatients and another 30 percent have Medicare. Raleigh Hills stressed that aftercare is³⁰ of the utmost importance for successful treatment of alcoholics.

Finally, a nurse from Sunrise Hospital emphasized to the subcommittee that alcoholism is a disease and should be covered. She pointed out that ongoing care is as much needed for alcoholism as for heart disease or diabetes.³¹

On the opposing side of the mandatory coverage for substance abuse issue was the Health Insurance Association of America (HIAA) which stated that it represents 320 member companies writing 80 percent of the health insurance nationally. HIAA's view is that insurance coverage will not solve substance abuse which is a social problem and should be dealt with by government and by employers. Mandatory insurance will act as a negative incentive to employers who will eschew their responsibility.

²⁷ Ibid, November 5 meeting, Carson City.

²⁸ Ibid, January 14 meeting, Las Vegas.

²⁹ Ibid, January 13 tour of facilities, Las Vegas.

³⁰ Ibid.

³¹ Ibid, January 14 meeting, Las Vegas.

According to HIAA, mandatory coverage will make premium costs rise and "for fee" programs will spring up to replace social programs such as Alcoholics Anonymous. Also mentioned as factors which detract from the concept of mandatory insurance coverage are substance abuse recidivism, undocumented success rate for treatment programs and the trend among consumers to seek reduced premiums for nonsmokers and nondrinkers.³² The president of Mutual Administrators, Inc., which administers health insurance for state government, predicted an unspecified cost increase in insurance premiums if the legislature mandates coverage for substance abuse treatment beyond detoxification. The Mutual Administrator president favored mandatory coverage of medical detoxification because it would entail little expense and would lead to more accurate diagnoses. The importance of followup programs was stressed again. The president indicated that under the state employee health insurance program, alcoholism treatment at a hospital is covered fully and 50 percent of outpatient services are covered under mental disorders if treatment is recommended by a physician. Also speaking against mandatory coverage was the Nevada Life Underwriters Association. This group opposed mandatory coverage of substance abuse treatment and called it a "hidden tax." The underwriters declared that they have not had sufficient time to ascertain costs of treatment. The subcommittee was asked to consider the desirability of asking alcohol abstainers³³ to subsidize substance abusers through insurance premiums.

Two employer groups told the legislative subcommittee of their reaction to mandatory coverage for substance abuse. A spokesman for the Nevada Chapter of Associated General Contractors stated that such a law would increase the cost of doing business and adversely affect consumers. When questioned about the possibility of exempting employers with their own substance abuse programs from mandatory coverage, the executive director of the Nevada Resort Association indicated that in either case there would be increased costs. Government mandated insurance for the private sector was opposed.³⁴

The state insurance division was officially neutral on the issue. A spokesman for the division stated that no information is available on the number of persons availing themselves of the state's existing law for optional substance abuse coverage.³⁵

³² Ibid, November 5 meeting, Carson City.

³³ Ibid, January 15 meeting, Las Vegas.

³⁴ Ibid.

³⁵ Ibid.

V. FINDINGS AND RECOMMENDATIONS

- A. Should the legislature mandate health insurance coverage for treatment of substance abuse? This was the central question addressed by the oversight subcommittee. The oversight subcommittee found that:

FINDINGS

1. The present law requiring such coverage to be offered apparently has not resulted in utilization of the option. The present trend is for insurers to cover only medical treatment in a hospital setting.
2. Precise fiscal data predicting direct costs of premiums and other indirect costs are unavailable for many reasons including:
 - a. Lack of segregated data by insurers on the specific illness.
 - b. Lack of applicability of cost studies such as the California pilot program to Nevada because of different benefit packages, geographical and population disparities and extremely low utilization rates.
3. It is unlikely that completely accurate fiscal data can be generated until several years experience have been monitored for a specific benefit package. It is for this reason that the National Blue Cross Association is undertaking a 2 to 3 year field test of its model benefit package.
4. Alcoholics probably utilize a disproportionate share of other health insurance benefits because they experience certain illnesses more frequently than non-alcoholics and because alcoholism is likely to be treated under a pseudo diagnosis.
5. National reports indicate that alcoholics are more likely than drug abusers to be employed and to have private health insurance coverage. Profiles of substance abusers from the Nevada bureau of alcohol and drug abuse confirm that while alcoholics in state funded treatment programs have a high unemployment rate, they are more likely to be employed and in the middle age bracket than are drug users. According to BADA statistics, client populations in alcohol and drug abuse programs are substantially different from one another.

6. The state of the art for treatment and improvement of illness appears to be more advanced in the field of alcoholism than in the area of drug abuse.
7. A recent survey of 20 major corporations in the nation revealed that employers regard alcoholism as a greater problem among employees than illicit drug use.
8. A survey of large health insurers in Nevada revealed that where state laws mandate coverage of substance abuse, benefit levels are usually greater. Additional premiums estimated for coverage in group policies ranged from zero to 85 cents per month per person. Estimated premium charges for substance abuse coverage in individual policies were considerably higher than for coverage in group policies. The six companies responding all sell health insurance in states with mandated coverage. None of the insurers keep separate data on claims attributed to alcoholism and drug abuse.
9. There are 14 states which mandate health insurance coverage of alcoholism treatment and five of them require coverage of drug abuse. The laws are fairly recent ones and no states had reliable fiscal information for use in predicting premium costs. A wide variety of benefits were required in these state laws and all but three states limited alcoholism coverage to group policies.
10. Alcoholism and drug abuse are serious problems in Nevada. The state's alcoholism rate is estimated to be 6.7 percent. There are no reliable estimates of drug abuse although federal crime statistics show that there were approximately 3,600 drug arrests in Nevada in 1977.
11. Information presented to the subcommittee was divided between providers of substance abuse care who favored mandatory health insurance coverage of substance abuse and insurance representatives who opposed legislation of this nature.
12. State and federal governments together spend approximately two million dollars yearly in Nevada on substance abuse programs.
13. A survey by the Nevada insurance division of insurance commissioners in states with mandatory coverage of substance abuse treatment confirmed the division's opinion that little data exists on claims experiences and costs in other states and that even if it did, it would be of little value in predicting costs for a different set of benefits and a different population in Nevada.

Therefore, the oversight subcommittee recommends that in order to encourage open treatment of alcohol abuse, to discourage the revolving door syndrome of detoxification only and to promote savings in terms of costs in treating related diseases and costs to society that:

RECOMMENDATION:

The legislature enact legislation mandating health insurance coverage of alcoholism treatment in new and renewed group policies, medical service corporation contracts and health maintenance plans. The effective date of the law should be 1980 to give the insurance commission and insurers time to prepare for the change. At this time, individual health insurance policies should not be required to include benefits for substance abuse coverage primarily because of substantially higher costs than anticipated in group type policies.

- B. What type of benefits and limitations should the required coverage include?

Having decided that the law should require coverage of alcoholism treatment in group type health insurance policies, the oversight subcommittee then discussed the type of coverage which should be mandated. The subcommittee found that:

FINDINGS:

1. Other states with mandatory coverage of substance abuse vary tremendously in benefit requirements and limitations. The usual categories of benefit limitation were inpatient versus outpatient care, type of facility, duration of treatment and dollar limitations. Half of the states with mandatory coverage require both outpatient and inpatient care and most require licensure of facilities by the state. Limitations on duration of treatment existed in half of the states with mandatory coverage. Maximum dollar limitations were found in four states.
2. Model benefit packages such as the Blue Cross model alcoholism plan and the California pilot program also utilized dollar and duration of treatment limitations. In addition, the Blue Cross model limited lifetime treatment to two benefit periods of 365 days plus a lifetime reserve of 60 outpatient visits. Both programs provided for outpatient treatment which included family counseling. Treatment in all the model alcoholism plans reviewed (Blue Cross, California pilot, NIAAA) allowed for non-medical care in freestanding treatment centers.

3. Information presented to the subcommittee by providers of alcoholism care generally stressed the importance of after-care to a successful program. On the other hand, a 1976 Rand study of alcoholism remission rates found that treatment modalities did not significantly affect recovery, but that increased amounts of treatment improved remission rates. Further, the Rand study showed little difference in remission rates between clients in outpatient care treated by paraprofessional counselors and those treated by professional therapists.

Therefore, the oversight subcommittee recommends that:

RECOMMENDATIONS:

The legislation which mandates coverage of alcoholism of treatment in group health insurance policies should:

1. Require a minimum of 5 days acute hospital care, 30 days inpatient treatment in a health and care facility and in major medical policies, 52 visits of outpatient care. Family counseling shall be allowed under outpatient benefits.
2. Limit required coverage to a lifetime maximum of two treatment periods, each one consisting of the day limits mentioned in the previous recommendation. A lifetime reserve of 60 outpatient visits shall be included in the minimum required coverage.
3. On a temporary basis the lifetime dollar benefit maximums should remain as they are in existing law--\$1,000 for inpatient care in a health and care facility and \$800 for outpatient treatment. An advisory task force should be created to:
 - a. Make recommendations to the 1981 legislature on appropriate dollar maximum benefit levels for the mandatory alcoholism coverage and on standards for determining these benefit levels.
 - b. Advise the insurance division on implementing the mandatory alcoholism benefits law.
 - c. Review the Nevada "credentialling" model for substance abuse programs and if necessary, recommend changes to the bureau of alcohol and drug abuse.

Members of the advisory task force should be appointed to serve in the interim between enactment of the law and the 1981 legislative session.

The advisory task force shall be composed of:

1 legislator appointed by the legislative commission
1 representative from the insurance division
1 representative from the bureau of alcohol and drug abuse
1 representative of the health insurance industry
and 1 consumer. With the exception of the legislative
member, task force members shall be appointed by the
governor.

4. Not require aftercare as a consideration for reimbursement.
- C. Should the mandatory coverage law prescribe facility eligibility for purposes of insurance reimbursement?

The subcommittee found that:

FINDINGS:

1. Requiring JCAH accreditation would be too costly.
2. Leaving facility approval to insurers would frustrate the intention of the law since insurers would have a tendency to allow medical facilities only.

Therefore, the subcommittee recommends that:

RECOMMENDATION:

Certification of staff, program accreditation and facility licensure by the state should be prerequisites for participation in the mandatory insurance program.

- D. Should alcoholism facilities built after the effective date of the mandatory insurance law be required to come under certificate of need legislation (NRS 439A)?

The oversight subcommittee finds that:

FINDING:

The possibility exists that facilities will be built to take advantage of required insurance coverage for treatment of alcoholism. This situation could result in overbuilding of intermediate care facilities, under-utilization and potentially higher costs to the consumer.

Therefore, the oversight subcommittee recommends that:

RECOMMENDATION:

Inpatient alcoholism care facilities, with medical supervision (not necessarily on the premises) and with highly structured rehabilitation programs, should be covered by 439A of NRS. The intent is to exclude less formal halfway houses or residential facilities.

Legal counsel informed the oversight subcommittee that existing Nevada law which includes intermediate care facilities already fulfills the intent of this recommendation. No bill draft will be required.

- E. Should the law requiring mandatory health insurance coverage of alcoholism contain provisions for data collection?

FINDING:

The oversight subcommittee weighed the value of collecting such data as cost and effectiveness of treatment against government's tendency to overburden public agencies and private enterprise with paperwork. Citing such factors as added costs for tasks which do not constitute direct service, the subcommittee chose not to recommend legislation requiring data collection.

- F. Should Nevada law requiring optional coverage of substance abuse treatment be amended?

FINDING:

The subcommittee finds that requiring benefits to be offered by insurers is still a valuable alternative for policies not affected by the proposed mandatory coverage.

Therefore, the subcommittee recommends that:

RECOMMENDATIONS:

1. Insurers should be required to offer individual policyholders alcoholism benefits equal to those mandated by group type policies.
2. Optional drug abuse benefits equal to mandatory alcoholism benefits should be required to be offered in individual and group health insurance policies, medical service corporation contracts and health maintenance plans.

APPENDIX A

EXISTING LAW
INSURANCE COVERAGE OF
ALCOHOL AND DRUG ABUSE

689A.030 Scope, format of policy. No policy of health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

... 9. The policy shall provide, at the option of the applicant, benefits for expenses incurred for the treatment of alcohol and drug abuse as provided in NRS 689A.047.

(Added to NRS by 1971, 1752; A 1973, 546; 1975, 446, 1108, 1848)

689A.047 Required provisions: Benefits for treatment of alcohol and drug abuse. The annual benefits provided by individual health insurance policies, as required by subsection 9 of NRS 689A.030, for the treatment of alcohol and drug abuse shall consist of:

1. If the policies are basic policies, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during such period.

2. If the policies are basic policies, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies are major medical policies, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of such inpatient treatment.

(Added to NRS by 1975, 1850)

689A.280 Intoxicants and narcotics.

1. There may be a provision as follows:

Intoxicants and Narcotics: The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

2. If the insurer includes the provision set forth in subsection 1, he shall also provide that such provision in no way affects benefits payable for the treatment of alcohol or drug abuse, as required by subsection 9 of NRS 689A.030.

(Added to NRS by 1971, 1763; A 1975, 1849)

689B.030 Required provisions in group policies. Each such group health insurance policy shall contain in substance the following provisions: ... 5. A provision for benefits, at the option of the applicant, payable for expenses incurred for the treatment of alcohol and drug abuse, as provided in NRS 689B.037.

(Added to NRS by 1971, 1767; A 1975, 443, 1850)

689B.037 Required provision concerning benefits for treatment of alcohol and drug abuse. The annual benefits provided by group health insurance policies, as required by subsection 5 of NRS 689B.030, for the treatment of alcohol and drug abuse shall consist of:

1. If the policies are basic policies, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during such period.

2. If the policies are basic policies, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025 for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies are major medical policies, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of such inpatient treatment.

(Added to NRS by 1975, 1851)

695B.180 Required provisions of contract. No hospital, medical or dental service contract shall be entered into between a corporation proposing to furnish or provide any one or more of the services authorized under this chapter and a subscriber: . . .

8. Unless the policy provides, at the option of the subscriber, services for treatment of alcohol and drug abuse as provided in NRS 695B.195.

695B.195 Benefits for expenses incurred for treatment of alcohol and drug abuse. The annual benefits provided by all individual and group service or indemnity-type contracts issued by a nonprofit corporation, as required by subsection 8 of NRS 695B.180, for the treatment of alcohol and drug abuse shall consist of:

1. If the policies are basic policies, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during such period.

2. If the policies are basic policies, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies are major medical policies, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of such inpatient treatment.

(Added to NRS by 1975, 1852)

695C.170 Evidence of coverage: Issuance; form and contents.

1. Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy, whether by option or otherwise, the insurer shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage. . .

3. An evidence of coverage shall contain:

(a) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation or which are untrue, misleading or deceptive as defined in subsection 1 of NRS 695C.300; and

(b) A clear and complete statement, if a contract, or a reasonably complete summary if a certificate, of: . . .

(5) A provision for benefits, at the option of the enrollee, for services for the treatment of alcohol and drug abuse, as provided in NRS 695C.175.

695C.175 Benefits for expenses incurred for treatment of alcohol and drug abuse. The annual benefits provided by all individual and group health care plans, as required by subparagraph (5) of paragraph (b) of subsection 3 of NRS 695C.170, for the treatment of alcohol and drug abuse shall consist of:

1. If the policies are basic policies, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during such period.
2. If the policies are basic policies, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025 for a period of not more than 30 days with a maximum benefit of \$1,000.
3. If the policies are major medical policies, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of such inpatient treatment.

(Added to NRS by 1975, 1853)

APPENDIX B

Pell and D'Alonzo

TABLE IX
FREQUENCY RATES OF ALCOHOLICS AND CONTROLS
BY DIAGNOSTIC CATEGORY

Diagnostic Category		No. of Absences	Frequency Rate (%)	Ratio of Frequency Rates: A/C
Respiratory infections	A	294	38.5	1.7
	C	194	22.5	
Digestive disorders	A	215	28.1	2.4
	C	103	11.9	
Musculoskeletal disorders	A	111	14.5	2.7
	C	46	5.3	
Virus infections, unspecified	A	53	6.9	1.3
	C	45	5.2	
Cardiovascular disease	A	40	5.2	1.9
	C	23	2.7	
Accidents	A	35	4.6	3.5
	C	11	1.3	
Alcoholism	A	26	3.4	—
	C	0	0.0	
Neurological disorders	A	23	3.0	1.5
	C	17	2.0	
Genitourinary disorders	A	19	2.5	0.6
	C	34	3.9	
Mental illness	A	15	2.0	3.3
	C	6	0.6	
Other illnesses	A	75	9.8	2.0
	C	42	4.9	
Unknown	A	78	10.2	1.8
	C	48	5.6	
Total	A	984	128.8	2.0
	C	569	65.9	

* A = Alcoholics; C = Controls.

Source: Sidney Pell and C. A. D'Alonzo, "Sickness Absenteeism of Alcoholics," in Journal of Occupational Medicine, Volume 12, no. 6 (June 1970), p. 205.

APPENDIX C

TREATMENT OUTCOMES FOR ALCOHOLICS IN NIAAA PROGRAMS

REMISSION RATES FOR TREATED AND UNTREATED ALCOHOLICS*

Remission Status	Remission Rates (%)				
	Untreated Alcoholics		Treated Alcoholics		
	Single Contact	Preintake	Low Amount of Treatment	High Amount of Treatment	All Treated Clients
Remissions	53	54	58	73	67
Abstained 6 months	11	15	22	26	24
Abstained 1 month	13	13	16	21	21
Normal drinking	29	27	20	26	22
Nonremissions	47	46	42	27	33
Daily consumption (oz)	3.3	3.0	2.9	2.2	2.5
(N)	(105)	(136)	(184)	(272)	(596)

*At 18 months.

EFFECTS OF OTHER TREATMENT IN PAST YEAR ON REMISSION RATES OF ALCOHOLICS TREATED AND UNTREATED BY ATCs

Other (Non-ATC) Treatment	Remission Rates (%)			
	Alcoholics Untreated by ATC		Alcoholics Treated by ATC	
	Single Contact	Preintake	Low Amount of Treatment	High Amount of Treatment
None	53	56	58	83
(N)	(97)	(79)	(95)	(112)
AA Only	56	56	63	72
(N)	(27)	(32)	(51)	(116)
Other Treatment	54	48	50	55
(N)	(26)	(25)	(38)	(44)

Source: David J. Armor, J. Michael Polich and Harriet B. Stambul, Alcoholism and Treatment (Rand Corporation, June 1976), pp. 95 and 97.

APPENDIX D

TREATMENT OUTCOMES FOR ALCOHOLICS IN NIAAA PROGRAMS

CLIENT TREATMENTS CLASSIFIED BY TREATMENT SETTING

Treatment Setting Category Code	Treatments Received by Client	Duration of Treatment ^a	(N)
H	Hospital care alone	1	(141)
I	Intermediate care alone		
	Intermediate care and hospital care	8	(265)
O	Outpatient care alone	7	(820)
HO	Hospital care and outpatient care	7	(661)
IO	Intermediate care and outpatient care		
	Intermediate, outpatient, and hospital care	8	(448)

^aMonths between intake and last treatment (median), all 44 ATCs.

REMISSION RATES OF CLIENTS IN FIVE TREATMENT SETTINGS

Remission Status	Treatment Setting					All Settings
	H	I	O	HO	IO	
<i>6-Month Followup</i>						
Percent remissions	70	78	70	62	67	68
Abstained 6 months	14	19	21	14	17	18
Abstained 1 month	48	49	34	36	40	38
Normal drinking	8	10	15	12	10	12
Percent nonremissions	30	22	30	38	33	32
Daily consumption (oz)	2.9	1.9	1.5	2.6	2.4	2.1
(N)	(133)	(251)	(797)	(627)	(426)	(2234)
<i>18-Month Followup</i>						
Percent remissions	78	56	69	74	61	67
Abstaining 6 months	29	15	26	26	25	24
Abstaining 1 month	25	30	15	25	16	21
Normal drinking	24	12	29	23	20	22
Percent nonremissions	22	44	31	26	39	33
Daily consumption (oz)	1.6	4.1	1.8	2.0	2.8	2.5
(N)	(59)	(108)	(157)	(126)	(134)	(584)

CLIENT BACKGROUND DIFFERENCES AMONG TREATMENT SETTINGS^a

Background Characteristics	Treatment Setting				
	H	I	O	HO	IO
	Client Population (%)				
Definitely alcoholic at intake	83	78	56	83	77
Unstable at intake	15	71	30	41	44
Low socioeconomic status at intake	27	54	42	38	55
(N)	(60)	(108)	(158)	(127)	(134)

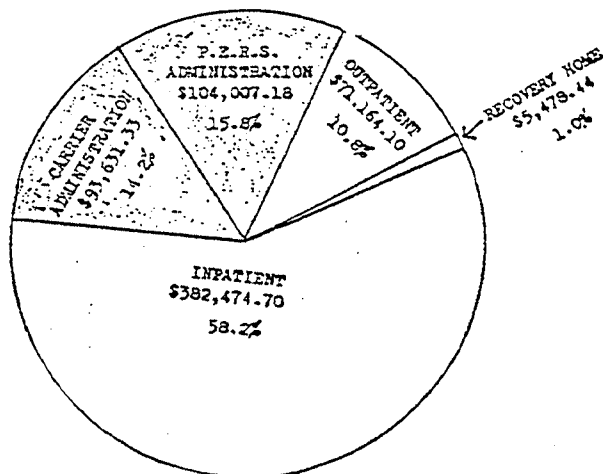
^aFor 18-month followup sample; 6-month sample patterns (not shown) are very similar.

Source: David J. Armor, J. Michael Polich and Harriet B. Stambul, Alcoholism and Treatment (Rand Corporation, June 1976), pp. 103, 104 and 107.

DATA ON THE CALIFORNIA PILOT PROGRAM*
Health Insurance for Alcoholism

Summary of Pilot Program Costs

When all expenses are taken into account, total Pilot Program cost (through the end of June 1976) came to \$656,755.75. This includes P.E.R.S. administrative expenses, carrier administrative expenses and benefits paid for treatment under the program. A breakdown of total program cost is shown in the following pie-chart.



Average Per Person Costs and Benefits Paid

	Inpatient		Outpatient		Total*	
	Cost	Benefits	Cost	Benefits	Cost	Benefits
All Carriers	\$1,732.57	1,521.27	153.15	137.87	884.57	778.31

Inpatient Utilization and Cost by Type of Facility

1. Percentage distributions of admissions, days, costs and benefits by facility type.

Facility	Admissions	Days	Cost	Benefits
General Hospital	37.8	11.8	16.6	18.0
Alcohol Unit	34.8	52.2	50.6	53.9
Alcohol Hospital	20.6	25.2	27.7	23.2
Community Center	2.6	2.5	0.6	0.6
Res. Treatment	2.8	7.8	3.9	3.7
Other	1.4	0.5	0.6	0.6
	100.0	100.0	100.0	100.0

2. Average costs per day by type of facility.

All Plans:

General Hospital	Alcohol Unit	Alcohol Hospital	Co. Alc. Center	Total - All Facilities
169.72	115.85	132.14	28.07	123.21

Percentage Distribution of Outpatient Benefits

All Carriers:

Physician	Counselor	LSW	Psychol.	Para-Prof.	Total
44.1	2.4	7.2	7.1	39.2	100.0

Source: Health Benefits Division, California Pub. Emp. Retirement System, Alcohol Pilot Program, June 1974 May 1976, Final Report, pp. 4, 6, 7 and 13.

APPENDIX F
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
NATIONAL COUNCIL ON ALCOHOLISM

GENERAL FINDINGS - MEDIAN TOTAL COSTS OF SERVICES

	INPATIENT EMERGENCY CARE					INPATIENT CARE				INTERMEDIATE CARE				OUTPATIENT CARE		
	GENERAL HOSPITAL	SPE- CIALIZED ALCOHOL- ISM HOSPITAL	OTHER SPECIALIZED HOSPITAL	HOSPITAL- AFFILIATED MEDICAL EMERGENCY CARE CENTER	HOSPITAL- AFFILIATED NON MEDICAL EMERGENCY CARE CENTER	GENERAL HOSPITAL	SPECIALIZED ALCOHOLISM HOSPITAL	OTHER SPECIALIZED HOSPITAL	HOSPITAL- AFFILIATED INPATIENT CARE UNDER MEDICAL SUPERVISION	PARTIAL HOSPITAL- IZATION	RECOVERY HOME	OTHER 24 HR. NON-MEDICAL RESIDENTIAL CENTER	SPECIALIZED ALCOHOLISM HOSPITAL	HOSPITAL- BASED OUTPATIENT CLINIC	FAMILY OR NEIGHBOR- HOOD ALCOHOLISM CENTER	COMMUNITY MENTAL HEALTH CENTER
COST PER CLIENT DAY	\$ 171.58	\$ 67.70	\$ 87.39	\$ 78.65	\$ 16.39	\$ 87.38	\$ 33.78	\$ 83.66	\$ 117.00	\$ 74.16	\$ 12.66	\$ 31.08	\$ 28.74	\$ 28.07	\$ 15.84	\$ 32.22
COST PER CLIENT STAY	\$ 549.14	\$ 230.84	\$ 471.58	\$ 148.16	\$ 53.81	\$ 766.24	\$ 270.21	\$ 923.98	\$ 1,173.71	\$ 1,274.21	\$ 687.82	\$ 735.17	\$ 192.88	\$ 60.23	\$ 219.87	\$ 300.87
AVERAGE LENGTH OF STAY	4 DAYS	4 DAYS	4.8 DAYS	3.8 DAYS	3.1 DAYS	16.4 DAYS	8.0 DAYS	8.4 DAYS	8.2 DAYS	16.8 DAYS	66 DAYS	29.8 DAYS	30.3 DAYS	13 VISITS	11.7 VISITS	8.3 VISITS
MAXIMUM LENGTH OF STAY UNDER MODEL BENEFIT PACKAGE	6 DAYS	6 DAYS	6 DAYS	6 DAYS	6 DAYS	14 DAYS	14 DAYS	14 DAYS	14 DAYS	28 DAYS	60 DAYS	28 DAYS	28 DAYS	46 VISITS	46 VISITS	46 VISITS
MODEL BENEFIT PACKAGE SUFFICIENT?	4 YES	3 YES	1 YES 1 NO	6 YES	2 YES	2 YES	2 YES 1 NO	1 YES 1 NO	3 YES	2 YES	3 YES 2 NO	3 YES 6 NO	1 YES 1 NO	6 YES	4 YES	11 YES
MAXIMUM COST \$ OF MODEL BENEFIT PACKAGE	\$ 1,079.38	\$ 346.78	\$ 688.78	\$ 471.30	\$ 88.31	\$ 1,223.26	\$ 472.82	\$ 1,311.24	\$ 1,638.00	\$ 2,078.20	\$ 769.60	\$ 990.08	\$ 748.58	\$ 803.16	\$ 638.68	\$ 1,449.90

BOOZ, ALLEN & HAMILTON
JANUARY 1974

Source: Booz, Allen and Hamilton, Model Benefits Costs in Alcoholism Treatment Programs,
Report for NIAAA (1974), p. 13.

APPENDIX G

ESTIMATED COSTS OF MODEL HEALTH INSURANCE COVERAGE FOR DRUG ABUSE

1. Potential Costs of the Model Benefit Plan

<u>Treatment Setting</u>	<u>Maximum Length of Stay</u>	<u>Potential Costs of Care</u>
A. Inpatient	7 days per sequence x 3 admissions = 21 days	\$104 x 10 = \$1,040 (Based on 10 days of care)
B. Intermediate	60 days per sequence x 3 admissions = 180 days	\$24 x 90 = \$2,160 (Based on 90 days of care)
C. Outpatient	45 visits per benefit period	\$27 (average cost for group and individual counseling) x 45 = \$1,125

2. SUMMARY OF TREATMENT SETTING COSTS BY STUDY SOURCE

<u>Treatment Setting</u>	<u>Costs by Source</u>			
	<u>Treatment Centers^a Visited</u>	<u>SRI & CPRI Study^b</u>	<u>Estimated Range of Costs Using One-Half of Available Benefits</u>	<u>Estimated Range of Costs Using Full Benefits</u>
1. Inpatient	\$112/day	\$97/day ¹	\$104 x 10 days = \$1,040.00	\$104 x 21 days = \$2,184.00
2. Intermediate	\$ 15/day	\$32.74/day ¹	\$24 x 90 days = \$2,160.00	\$24 x 180 days = \$4,320.00
3. Outpatient	\$ 20/visit	\$34.95/visit ²	\$27 x 22 visits = \$594	\$27 x 45 visits = \$1,215.00

NOTES: a) Data obtained from site visits by H-2, Inc. to drug treatment centers, 1975.

b) Peter B. Bjorklund, et al "A Survey of Drug Abuse Treatment Costs", The Stanford Research Institute and The Center for Planning and Research, Incorporated, (unpublished draft final report prepared for National Institute on Drug Abuse, 1975).

1) Costs derived from SRI study, Table III-4, pg. III-5.

2) Costs derived from SRI study, pg. IV-4.

SOURCE: Jerome B. Mallan, Harold Holder, Martha J. Stucker, Linda B. Latta, Model Health Insurance Benefit Plan for the Treatment of Drug Abuse. (Cary, N.C., 1975), pp. VI 33-34.

DOES YOUR STATE REQUIRE MANDATORY INSURANCE COVERAGE OF ALCOHOL,
DRUG AND MENTAL HEALTH TREATMENT?

RESPONDENTS	ALCOHOL	DRUG ABUSE	MENTAL HEALTH
<u>STATES</u>	<u>Yes/No</u>	<u>Yes/No</u>	<u>Yes/No</u>
Alabama	X	X	X
Alaska	X	X	X
Arizona	X	X	X
Arkansas	X	X	X
California	X	X	1
Colorado	2	X	✓
Connecticut	✓	X	✓
Delaware	X	X	X
Florida	X	X	3
Georgia	X	X	X
Hawaii	✓	✓	4
Idaho	X	X	X
Illinois	✓	X	5
Indiana	NR	NR	NR
Iowa	X	X	X
Kansas	NR	NR	NR
Kentucky	X	X	X
Louisiana	6	X	6
Maine	NR	NR	NR
Maryland	7	X	7
Massachusetts	✓	X	✓
Michigan	NR	NR	NR
*Minnesota	✓	✓	NR
Mississippi	✓	X	X
Missouri	✓	X	X
Montana	X	X	X
Nebraska	NR	NR	NR
Nevada	8	8	X
New Hampshire	X	X	✓
New Jersey	✓	X	X
New Mexico	X	X	X
New York	X	X	9

July 20, 1978

APPENDIX H

Respondants/States	ALCOHOL	DRUG ABUSE	MENTAL HEALTH
	Yes/No	Yes/No	Yes/No
North Carolina	10	10	10
North Dakota	✓	✓	✓
Ohio	✓	X	✓
Oklahoma	NR	NR	NR
Oregon	✓	X	X
Pennsylvania	NR	NR	NR
Rhode Island	X	X	X
South Carolina	X	X	X
South Dakota	11	X	X
Tennessee	X	X	X
Texas	X	X	X
Utah	X	X	X
Vermont	NR	NR	NR
Virginia	✓	✓	✓
Washington	✓	X	X
West Virginia	12	X	12
Wisconsin	✓	✓	✓
Wyoming	X	X	X
TOTALS :	<u>Yes/No</u> 14 28	<u>Yes/No</u> 5 37	<u>Yes/No</u> 8 33
	<u>NR</u>	<u>NR</u>	<u>NR</u>
	8	8	9

*Minnesota did not respond to the survey. Information was obtained from their statutes.

APPENDIX H

1. California requires group disability insurance to offer coverage of mental disorders under terms agreed upon between the insurer and group policy holder.
2. Colorado group health insurance is required to offer option to purchaser for treatment of alcoholism. Colorado Blue Cross/Blue Shield indicate that extending the alcoholism coverage from 30 to 45 hospital days resulted in a \$3 annual premium increase for individuals and \$6.72 for families.
3. Florida group health insurance is required to make available benefits for the care of mental and nervous disorders for an additional premium.
4. Hawaii law does not specifically require coverage for mental illness, but payments are allowed in practice to psychiatrists and psychologists according to the Legislative Reference Bureau.
5. Illinois group health and accident policies must offer coverage for mental disorders.
6. Louisiana requires insurers offering health and accident policies to make available treatment for mental disorders and alcoholism, at the option of the policyholder.
7. Maryland requires group health insurers to offer the group policy holder the option of coverage for alcoholism and psychiatric care for an additional premium.
8. Nevada insurers of individual and groups must provide benefits for expenses for treatment of alcohol and drug abuse, at the option of the applicant.
9. New York requires group insurers to cover mental disorders if the contract holder so requests.
10. North Carolina requires health policies to cover charges for treatment in state supported facilities, including mental health centers, on the same basis as if the treatment had been rendered by any other private or public institution.
11. South Dakota requires that health insurers must offer coverage for inpatient treatment of alcoholism in individual and group health policies.
12. West Virginia requires group accident and sickness insurers to make available coverage of expenses arising from mental conditions. Individual accident and sickness insurance policies shall provide, unless refused by the policyholder, benefits for expenses of mental conditions.

APPENDIX H

DESCRIPTIONS OF LAWS REQUIRING
HEALTH INSURANCE COVERAGE OF
ALCOHOLISM AND/OR DRUG ABUSE

CONNECTICUT

Type of policy affected: Group, Group Medical Expense,
Medical Service Plan Contract.

Benefits: Covers treatment for alcoholism or
medical complications such as
cirrhosis of the liver. Regular
hospital confinement is treated like
any other disease. Confinement in a
facility designed for treatment of
alcoholism is limited to 45 days in
12 consecutive months or in a
calendar year. Outpatient treatment
is required to be an option in group
policies.

Fiscal Information: None.

HAWAII

Type of policy affected: Prepaid health care plans.

Benefits: Inpatient and outpatient benefits
for substance abuse shall not be
less than for any other illness,
except that detoxification and acute
care benefits for alcoholism are
limited to 3 admissions per year,
not to exceed 21 days per admission.

Fiscal information: None.

ILLINOIS

Type of policy affected: Group accident and health policies with
inpatient coverage for general sicknesses.

Benefits: Inpatient hospital treatment for
alcoholism.

Fiscal information: None.

MASSACHUSETTS

Type of policy affected: All general health insurance, Medical
service plans and contracts.

Benefits: Alcoholism only. Inpatient hospitaliza-
tion or care in a licensed treatment
center must be covered for at least
30 days per year. Outpatient coverage
of \$500 for a 12 month period.

Fiscal information: None.

MINNESOTA

Type of policy affected: All accident and health policies and
health service plans (except
individual, non-group policies)

APPENDIX H

MINNESOTA (continued)

Benefits: Covers alcoholism, chemical dependency and drug addiction in licensed hospitals. Coverage for treatment at hospital and residential programs is for at least 20 percent of patient days allowable under the policy and for no less than 28 days in a 12 month benefit year. Coverage for non-residential treatment is for at least 130 hours in a 12 month benefit year.

Fiscal information: No response.

MISSISSIPPI

Type of policy affected: Group health and accident policies, nonprofit health plan corporations.

Benefits: Covers alcoholism only. Care and treatment of alcoholism is on the same basis as other benefits, except that coverage is limited to \$1,000 per calendar year and applies only to services rendered by physicians and hospitals licensed by the state.

Fiscal information: None.

MISSOURI

Type of policy affected: Group health insurance policies providing coverage on an expense incurred basis, nonprofit corporation group service contracts, self insured group health benefit plans.

Benefits: Coverage for hospital treatment of alcoholism.

Fiscal information: None.

NEW JERSEY

Type of policy affected: Individual contracts providing hospital or medical expense benefits, group health, hospital service corporation contracts, medical service corporation contracts.

Benefits: Alcoholism only. Coverage shall be provided to the same extent as for any other sickness under the contract. Coverage must include inpatient or outpatient care in a licensed hospital, treatment at a licensed detoxification facility and confinement at licensed residential treatment facility with minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation.

Fiscal information: None for the state's law. New Jersey used data compiled by other sources such as NIAAA.

APPENDIX H

NORTH DAKOTA

Type of policy affected: Group health, nonprofit hospital or medical service corporation which covers 50 or more persons and where the number of persons covered represents more than 70% of all persons eligible for coverage.

Benefits: Covers alcoholism, drug addiction and related illnesses. Inpatient treatment must be covered for at least 70 days of a calendar year. Partial hospitalization benefits are required for a minimum of 140 days per calendar year. Combination treatment is also provided on the basis that inpatient treatment equals 2 days of partial hospitalization treatment.

Fiscal information: None.

OHIO

Type of policy affected: Group, person or government providing health benefits for employees (self insured), hospital service corporations or associations, health care corporations and medical care corporations.

Benefits: Covers alcoholism care for outpatient, inpatient and intermediate care treatment with a \$500 minimum benefit in any 12-month period. Services must be performed by or under the supervision of a licensed physician or psychologist in a facility approved by JCAH or certified by the department of health. To qualify for participation a facility must have utilization review and peer review. To be eligible for continued alcohol benefits, treated person must be certified by the licensed physician or psychologist every 3 months. Program has sunset provision after 4 years.

Fiscal information: None

OREGON

Type of policy affected: Group health.

Benefits: Limited to alcoholism. Hospital expense coverage may be limited to treatment by a licensed health care facility, JCAH accredited facility or rehabilitation clinic established by the mental health division. Payments for treatment shall not be limited to an amount less than \$3,000 in any 24-consecutive month period.

Fiscal information: None.

APPENDIX H

VIRGINIA

Type of policy affected: All individual, and group accident and sickness insurance policies providing coverage on an expense incurred basis and contracts issued by nonprofit corporations.

Benefits: Coverage for mental, emotional or nervous disorders (the definition of which includes dependence upon alcohol and drugs) in hospitals on the same basis as any other illness, except that benefits may be limited to 30 days or treatment in any policy year. Group policies must make available additional outpatient benefits. Coverage of substance abuse treatment at inpatient facilities, intermediate care facilities and outpatient facilities must be made available as an option by individual and group accident and sickness insurers.

Fiscal information: None.

WASHINGTON

Type of policy affected: Group disability, health care service contracts.

Benefits: Coverage for treatment of alcoholism in approved facilities must be included in insurance contracts.

Fiscal information: No response.

WISCONSIN

Type of policy affected: Group disability, group hospital treatment contracts.

Benefits: Covers inpatient hospital treatment of alcoholism and drug abuse for not less than 30 days confinement per calendar year. Policies which cover outpatient treatment must include outpatient services for alcohol and drug abuse of at least \$500 per calendar year. Nonprofit service plans are required to provide outpatient hospital treatment of alcoholism in addition to group disability policies.

Fiscal information: The Blue Cross Plan for Wisconsin filed a monthly rate of \$.69 for individuals and \$1.99 for families in response to the 1975 requirement that they cover outpatient treatment of alcoholism and kidney disease. The rates were accepted with the understanding that they would be reviewed later in light of experience.

APPENDIX I

ESTIMATED RATES OF ALCOHOLISM IN NEVADA FOR 1976 BASED ON CIRRHOSIS DEATHS

REGION	TOTAL NUMBER OF ALCOHOLICS	PERCENTAGE OF ALCOHOLICS 15 YEARS OLD AND OLDER
LAS VEGAS	15,816	6.6%
RENO	8,702	8.0%
RURAL	4,499	5.2%
TOTAL	29,017	6.7%

Source: Bureau of Alcohol and Drug Abuse, The Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse, 1977-78 (Carson City, 1977), p. 11.

APPENDIX J

NEVADA

ALCOHOL CLIENT CHARACTERISTICS BY MULTIPLE VARIABLES AT ADMISSION

CHARACTERISTIC	1976 TREND
MEAN AGE AT ADMISSION	41.2
PERCENT MALES TREATED	78.6%
ETHNICITY	
White	85.7%
Black	7.5%
Spanish Descent	4.8%
American Indian	1.6%
Alaskan Native	.0%
Asian Descent	.0%
Other	.5%
MEDIAN SCHOOL YEARS	12.5%
MARITAL STATUS	
Married	22.1%
Divorced/Separated	54.9%
Single/Widowed	23.0%
PERCENT UNEMPLOYED	66.1%
PERCENT IN WORK FORCE	87.2%
PERCENT HAVING PRIOR TREATMENT	39.7%
MEAN INCOME LAST YEAR	\$7,534
YEARS HEAVY DRINKING	15.2
YEARS LIVING IN COMMUNITY	6.5
ALCOHOL CONSUMED/DAY (ounces)	10.5
OCCUPATION	
Professional	12.8%
Sales & Clerical	9.2%
Craftsmen	22.5%
Laborers	13.1%
Service	22.5%
Student/Housewife	6.0%
None	8.0%
Casino Workers	6.0%

Source: Bureau of Alcohol and Drug Abuse, The Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse, 1977-78 (Carson City, 1977), p. 14.

APPENDIX K

Table 3.8

DRUG ABUSE RATES IN NEVADA, BY REGION

Region	Total Arrests, 1972 ^a	Estimated "Heavy" Usage Based on 1974 State Survey ^b	
		Number	Rate
Las Vegas SMSA (Clark County)			
Marijuana	729	6,948	3.6%
Dangerous drugs ^c	729	4,246	2.2%
Opiates ^d	<u>238</u>	<u>965</u>	.5%
Total, Las Vegas area	1,596	12,159	
Reno SMSA (Washoe County)			
Marijuana	175	8,962	10.4%
Dangerous drugs	175	2,327	2.7%
Opiates	<u>58</u>	<u>1,551</u>	1.8%
Total, Reno area	408	12,840	
All other counties combined			
Marijuana	150	720	1.1%
Dangerous drugs	150	1,244	1.9%
Opiates	<u>49</u>	<u>393</u>	.6%
Total, other counties	349	2,357	
Nevada			
Marijuana	1,054	14,630	4.2%
Dangerous drugs	1,054	7,817	2.3%
Opiates	<u>345</u>	<u>2,909</u>	.8%
Total, Nevada	2,453	25,356	

^aTaken from *The Nevada State Plan for Drug Abuse Prevention, Treatment and Rehabilitation*, Governor's Advisory Board on Drug Abuse, Carson City, Nevada, 1973, pp. 29-30. Total arrests for each region are based on regional data; the breakdown of total arrests within each region by type of drug is based on the breakdown of the statewide total arrests by type of drug involved.

^bTaken from J. Pollard, *Survey of Nevada Rehabilitation Needs*, 1975, Nevada Rehabilitation Division, Department of Human Resources, Carson City, Nevada, 1975. "Heavy usage" in that survey means once a week or oftener. The dangerous drug rates were obtained by adding rates for hallucinogens, stimulants, and depressants. Numbers are based on the 1970 adult population of 344,680.

^cIncludes LSD, barbiturates, amphetamines, etc.

^dIncludes heroin, morphine, and other opiates.

Source: J. S. Kakalik, G. D. Brewer, L. L. Prusoff, D. J. Armor, P. A. Morrison, *Mental Health and Mental Retardation Services in Nevada* (Rand Corporation, Santa Monica, 1976), p. 92.

APPENDIX L
NEVADA

TYPES OF PRIMARY DRUG USED BY SELECTED CLIENT CHARACTERISTICS AT ADMISSION

PRIMARY DRUG	MEAN AGE AT ADMISSION	MEAN AGE AT FIRST USE	% UNEMPLOYED AT ADMISSION	SEX		RACE			
				% MALE	% FEMALE	% WHITE	% BLACK	% SPANISH	% OTHER
OPIATES	26.4	19.7	73.8	68.1	31.9	58.3	34.0	5.6	2.1
ALCOHOL	20.2	14.4	93.3	80.0	20.0	63.3	10.0	26.7	0
BARBITUATES	18.7	15.8	71.3	62.0	38.0	79.1	13.2	5.4	2.3
AMPHETAMINES	19.5	15.7	70.3	58.3	41.2	84.0	16.0	0	0
MARIJUANA	17.9	14.8	75.4	73.8	26.2	65.6	9.8	21.3	3.3
OTHER	18.3	15.06	72.7	57.6	42.4	80.0	12.5	5.0	2.5

Source: Bureau of Alcohol and Drug Abuse, The Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse, 1977-78 (Carson City, 1977), p. 22.

APPENDIX M

NEVADA

TREATMENT OUTCOME BY DRUG TYPE

PRIMARY DRUG	% SUCCESS*	% FAILURE
OPIATES	10.7	89.3
BARBITURATES	0	100.0
AMPHETAMINES	34.5	65.5
MARIJUANA	26.5	73.5
OTHER	21.4	78.6
POLYDRUG	33.6	66.1

* Completed treatment.

Source: Bureau of Alcohol and Drug Abuse, The Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse, 1977-78 (Carson City, 1977), p. 27.

APPENDIX N
EXISTING SUBSTANCE ABUSE
PROGRAMS IN NEVADA

1. Funded by Bureau of Alcohol and Drug Abuse

	<u>Drug</u>	<u>Alcohol</u>	<u>Combined</u>	<u>Total</u>
Central Intake	0	0	2	2
Medical Alcohol Detox	0	1	0	1
Social Alcohol Detox	0	2	0	2
Methadone Detox	1	0	0	1
Outpatient	5	3	7	15
Residential	2	4	0	6
Combined Residential & Outpatient	3	0	0	3
Juvenile Day Care	<u>0</u>	<u>0</u>	<u>1</u>	<u>1</u>
TOTAL:	12	10	9	31

2. Other, non-BADA funded programs

Hospitals

Care Unit North Las Vegas Hospital
Nevada Mental Health Institute
Raleigh Hills Hospital
Sunrise Hospital Drug Recovery Unit

*BADA Accredited Programs

**In process of BADA accreditation

Residential

Entitas

*Gemini House
Home of the Good Shepherd
Regina Hall
Samaritan House
We Care Foundation

Out Patient

*Clark County Health District Addiction Treatment Clinic (Methadone)
**Court Referral Services
*Curalogos Corporation
Echoes of Faith
Family Counseling Service
Intertribal Council On Alcoholism (Las Vegas)
Intertribal Council on Alcoholism (Washoe County)
Nellis Air Force Base Drug and Alcohol Program
*United Professional Services, Inc. (Methadone)

Source: Nevada Bureau of Alcohol and Drug Abuse

APPENDIX O
INSURANCE COVERAGE OF CLIENTS
IN NEVADA BUREAU OF ALCOHOL AND DRUG ABUSE

<u>Type of Insurance</u>	<u>Nevada</u>
No Health Insurance	72%
Blue Cross/Blue Shield	2%
Other Private Insurance	19%
Medicare/Medicaid	1%
CHAMPUS	1%
Other Public Funds	2%
Unanswered	3%
	<u>100%</u>

Exclusive of 2,000 persons in alcohol detoxification programs.

TYPES OF SUBSTANCE ABUSE IN BADA PROGRAMS

Heroin	25%
Other Opiates & Synthetics	< 1%
Non-Rx Methadone	< 1%
Barbiturates	5%
Other Sedatives or Hypnotics	4%
Amphetamines	3%
Cocaine	< 1%
Marihuana/Hashish	8%
Hallucinogens	4%
Inhalants	< 1%
Over-the-Counter	< 1%
Tranquilizers	< 1%
None	2% ¹
Alcohol	46%

¹ Represents families or clients without problems at the time of admission

Limitations of this prime drug of abuse table are (1) alcohol detoxification clients are not included; (2) clients resulting from A.B. 334 appropriation are not included; and (3) frequently alcohol will be a secondary problem to drug abuse.

Source: Nevada Bureau of Alcohol and Drug Abuse.

APPENDIX P
NEVADA ALCOHOL RELATED FATALITIES

	<u>1974</u>	<u>1975</u>	<u>1976</u>
Fatal Accidents	187	193	192
Had Been Drinking	93 (50%)	106 (55%)	81 (42%)
Over .10 BAC	72 (39%)	73 (38%)	61 (32%)
Drugs	0	0	3 (02%)
Average BAC (of those over .10)	.207	.198	.213

Source: Nevada Office of Traffic Safety.

SUMMARY--Requires coverage for treatment of alcohol abuse in group policies. (BDR 57-89)

Fiscal Note: Effect on Local Government: No.
Effect on the State and on Industrial Insurance: No.

AN ACT relating to insurance; requiring coverage for treatment for the abuse of alcohol in group insurance policies; creating a temporary advisory task force; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND
ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 458 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. 1. An advisory task force, consisting of five members, is hereby created.

2. The governor shall appoint:

(a) One member who is a representative of the insurance division of the department of commerce.

(b) One member who is a representative of the bureau.

(c) One member who is a representative of the health insurance industry.

(d) One member who is a representative of the general public.

3. The legislative commission shall appoint one member who is a legislator.

Sec. 3. The task force shall:

1. Review the procedures employed by the bureau for certifying persons, accrediting programs and licensing facilities, and recommend any necessary changes to the bureau.

2. Advise the insurance division on carrying out the provisions of law relating to insurance coverage for treatment of the abuse of alcohol.

3. Advise the 1981 session of the legislature on appropriate maximum levels of benefits and methods of determining future benefit levels for insurance coverage for treatment of the abuse of alcohol.

Sec. 4. Chapter 689A of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The benefits provided by individual health insurance policies, as required by subsection 9 of NRS 689A.030, for treatment of the abuse of alcohol must consist of:

(a) If the policies provide inpatient benefits, room and board in a hospital for a period of not less than 5 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least 52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the

inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1;

and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,

flush during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of alcohol.

Sec. 5. NRS 689A.030 is hereby amended to read as follows:

689A.030 [No] A policy of health insurance shall not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

1. The entire money and other considerations therefor shall be expressed therein;

2. The time when the insurance takes effect and terminates shall be expressed therein;

3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, dependent children, from the time of birth as provided in NRS 689A.043, or any children under

a specified age which shall not exceed 19 years except as provided in NRS 689A.045, and any other person dependent upon the policyholder;

4. The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-face type of a style in general use, the size of which shall be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points (the "text" shall include all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions);

5. The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in NRS 689A.-050 to 689A.290, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

6. Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; [and]

7. The policy shall contain no provision purporting to make

any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner [.] ;

8. The policy shall provide benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007 [.] ; and

9. The policy shall provide, at the option of the applicant, benefits for expenses incurred for the treatment of alcohol and drug abuse as provided in section 4 of this act and NRS 689A.047.

Sec. 6. NRS 689A.047 is hereby amended to read as follows:

689A.047 The annual benefits provided by individual health insurance policies, as required by subsection 9 of NRS 689A.030, for the treatment of [alcohol and] drug abuse shall consist of:

1. If the policies [are basic policies,] provide inpatient benefits, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025,

for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 7. Chapter 689B of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The benefits provided by group health insurance policies, as required in subsection 6 of NRS 689B.030, for treatment of the abuse of alcohol must consist of:

(a) If the policies provide inpatient benefits, room and board in a hospital for a period of not less than 5 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least

52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1; and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,

flush during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of alcohol.

Sec. 8. NRS 689B.030 is hereby amended to read as follows:

689B.030 Each such group health insurance policy shall contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

2. A provision that the insurer will furnish to the policyholder

for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family unit.

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

4. A provision for benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007.

5. A provision for benefits, at the option of the applicant, payable for expenses incurred for the treatment of [alcohol and] drug abuse, as provided in NRS 689B.037.

6. A provision for benefits, both in new policies and renewals, payable for expenses incurred for the treatment of the abuse of alcohol, as provided in section 7 of this act.

Sec. 9. NRS 689B.037 is hereby amended to read as follows:

689B.037 The annual benefits provided by group health insurance policies, as required by subsection 5 of NRS 689B.030, for the treatment of [alcohol and] drug abuse shall consist of:

1. If the policies [are basic policies,] provide inpatient benefits, room and board in a hospital for a period not to exceed

10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025 for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 10. Chapter 695B of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The annual benefits provided by health insurance policies issued by a medical service corporation, as required by subsection 9 of NRS 695B.180, for treatment of the abuse of alcohol must consist of:

(a) If the policies provide inpatient care, room and board in a hospital for a period of not less than 5 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient care, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least 52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1;
and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,
during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of alcohol.

Sec. 11. NRS 695B.180 is hereby amended to read as follows:

695B.180 [No] A contract for hospital, medical or dental
[service contract shall] services shall not be entered into
between a corporation proposing to furnish or provide any one or

more of the services authorized under this chapter and a subscriber:

1. Unless the entire consideration therefor is expressed in the contract.

2. Unless the times at which the benefits or services to the subscriber take effect and terminate are stated in a portion of the contract above the evidence of its execution.

3. If the contract purports to entitle more than one person to benefits or services, except for family [hospital or medical or dental service] contracts issued under NRS 695B.190, group [hospital, medical or dental service] contracts issued under NRS 695B.200, and blanket contracts issued under NRS 695B.220.

4. Unless every printed portion and any endorsement or attached papers are plainly printed in type of which the face is not smaller than 10 points.

5. Except for group [hospital or group medical or dental service] contracts and blanket contracts issued under NRS 695B.220, unless the exceptions of the contract are printed with greater prominence than the benefits to which they apply.

6. Except for group [hospital or group medical or dental service] contracts and blanket contracts issued under NRS 695B.230, unless, if any portion of such contract purports, by reason of the circumstances under which an illness, injury or disablement is incurred to reduce any service to less than that provided for the same illness, injury or disablement incurred under ordinary circumstances, such portion is printed in boldface type and with

greater prominence than any other text of the contract.

7. If the contract contains any provisions purporting to make any portion of the charter, constitution or bylaws of such non-profit corporation a part of the contract unless [such] that portion is set forth in full in the contract.

8. Unless the policy provides, at the option of the subscriber, services for treatment of [alcohol and] drug abuse as provided in NRS 695B.195.

9. A provision for benefits, both in new policies and renewals, payable for expenses incurred for the treatment of the abuse of alcohol, as provided in section 10 of this act.

10. Unless [such] the contract for hospital service contains in blackface type, not less than 10 points, the following provisions:

Nothing contained in this contract shall in any manner restrict or interfere with the right of any individual entitled to hospital service and care hereunder to select the contracting hospital or to make a free choice of his attending physician, who shall be the holder of a valid and unrevoked physician's and surgeon's license and who is a member of, or acceptable to, the attending staff and board of directors of the hospital in which such hospital services are to be provided and rendered.

Sec. 12. NRS 695B.195 is hereby amended to read as follows:

695B.195 The annual benefits provided by all individual and group service or indemnity-type contracts issued by a nonprofit

corporation, as required by subsection 8 of NRS 695B.180, for the treatment of [alcohol and] drug abuse shall consist of:

1. If the policies [are basic policies,] provide inpatient benefits, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 13. Chapter 695C of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The benefits provided by health maintenance plans for treatment of the abuse of alcohol as required by subparagraph (6) of paragraph (b) of subsection 3 of NRS 695C.170, must consist of:

(a) If the policies provide inpatient care, room and board in a hospital for a period of not less than 5 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient care, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least 52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1;
and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,
flush during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of alcohol.

Sec. 14. NRS 695C.170 is hereby amended to read as follows:

695C.170 1. Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy, whether by option or otherwise, the insurer shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

2. [No evidence] Evidence of coverage or amendment thereto shall not be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment thereto has been filed with and approved by the commissioner.

3. An evidence of coverage shall contain:

(a) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation or which are untrue, misleading or deceptive as defined in subsection 1 of NRS 695C.300; and

(b) A clear and complete statement, if a contract, or a reasonably complete summary if a certificate, of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner the services may be obtained;

(4) The total amount of payment for health care services and

the indemnity or service benefits, if any, which the enrollee is obligated to pay; and

(5) A provision for benefits, at the option of the enrollee, for services for the treatment of [alcohol and] drug abuse, as provided in NRS 695C.175.

(6) A provision for benefits, both in new policies and renewals, payable for expenses incurred for the treatment of the abuse of alcohol, as provided in section 13 of this act.

-flush Any subsequent change may be evidenced in a separate document issued to the enrollee.

4. A copy of the form of the evidence of coverage to be used in this state and any amendment thereto shall be subject to the filing and approval requirements of subsection 2 unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance in which event the filing and approval provisions of such laws apply. To the extent however that such provisions do not apply to the requirements in subsection 3, such provisions are amended to incorporate the requirements of subsection 3 in approving or disapproving an evidence of coverage required by subsection 2.

Sec. 15. NRS 695C.175 is hereby amended to read as follows:

695C.175 The annual benefits provided by all individual and group health care plans, as required by subparagraph (5) of paragraph (b) of subsection 3 of NRS 695C.170, for the treatment of [alcohol and] drug abuse shall consist of:

1. If the policies [are basic policies,] provide inpatient benefits, room and board in a hospital for a period not to exceed

10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025 for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 16. 1. This act shall become effective on July 1, 1980.

2. Sections 2 and 3 of this act shall expire on July 1, 1981.

SUMMARY--Changes coverage for treatment of drug abuse in health insurance policies. (BDR 57-94)

Fiscal Note: Effect on Local Government: No.
Effect on the State and on Industrial Insurance: No.

AN ACT relating to insurance; changing coverage for treatment for the abuse of drugs in health insurance policies; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The annual benefits provided by individual health insurance policies, as required by subsection 9 of NRS 689A.030, for the treatment of drug abuse must consist of:

(a) If the policies provide inpatient benefits, room and board in a hospital for a period of not less than 5 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.-007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least

52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1; and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,

-flush during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of drugs.

Sec. 2. NRS 689A.030 is hereby amended to read as follows:

689A.030 [No] A policy of health insurance shall not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

1. The entire money and other considerations therefor shall be expressed therein;

2. The time when the insurance takes effect and terminates shall be expressed therein;

3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be

deemed the policyholder, any two or more eligible members of that family, including the husband, wife, dependent children, from the time of birth as provided in NRS 689A.043, or any children under a specified age which shall not exceed 19 years except as provided in NRS 689A.045, and any other person dependent upon the policyholder;

4. The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-face type of a style in general use, the size of which shall be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points (the "text" shall include all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions);

5. The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in NRS 689A.-050 to 689A.290, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

6. Each such form, including riders and endorsements, shall be

identified by a form number in the lower left-hand corner of the first page thereof; [and]

7. The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner [.] ;

8. The policy shall provide benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007 [.] ; and

9. The policy shall provide, at the option of the applicant, benefits for expenses incurred for the treatment of alcohol and drug abuse as provided in NRS 689A.047 [.] and section 1 of this act.

Sec. 3. 689A.047 is hereby amended to read as follows:

689A.047 The annual benefits provided by individual health insurance policies, as required by subsection 9 of NRS 689A.030, for the treatment of alcohol [and drug abuse] shall consist of:

1. If the policies [are basic policies,] provide inpatient benefits, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient

benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 4. Chapter 689B of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The annual benefits provided by group health insurance policies, as required by subsection 5 of NRS 689B.030, for the treatment of drug abuse must consist of:

(a) If the policies provide inpatient benefits, room and board in a hospital for a period of not less than 5 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department

of human resources pursuant to NRS 458.025 for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least 52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1;
and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,
flush during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of drugs.

Sec. 5. NRS 689B.030 is hereby amended to read as follows:

689B.030 Each such group health insurance policy shall contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written

instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

2. A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family unit.

3. A provision that to the group originally insured may be added from time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

4. A provision for benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007.

5. A provision for benefits, at the option of the applicant, payable for expenses incurred for the treatment of alcohol and drug abuse, as provided in NRS 689B.037 [.] and section 4 of this act.

Sec. 6. NRS 689B.037 is hereby amended to read as follows:

689B.037 The annual benefits provided by group health insurance policies, as required by subsection 5 of NRS 689B.030, for the treatment of alcohol [and drug abuse] shall consist of:

1. If the policies [are basic policies,] provide inpatient benefits, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025 for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 7. Chapter 695B of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The annual benefits provided by all individual and group service or indemnity-type contracts issued by a nonprofit corporation, as required by subsection 8 of NRS 695B.180, for the treatment of drug abuse must consist of:

(a) If the policies provide inpatient benefits, room and board in a hospital for a period of not less than 5 days and all the

necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025, for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least 52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1; and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,
flush during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of drugs.

Sec. 8. NRS 695B.180 is hereby amended to read as follows:

695B.180 [No] A contract for hospital, medical or dental
[service contract shall] service shall not be entered into

between a corporation proposing to furnish or provide any one or more of the services authorized under this chapter and a subscriber:

1. Unless the entire consideration therefor is expressed in the contract.

2. Unless the times at which the benefits or services to the subscriber take effect and terminate are stated in a portion of the contract above the evidence of its execution.

3. If the contract purports to entitle more than one person to benefits or services, except for family [hospital or medical or dental service] contracts issued under NRS 695B.190, group [hospital, medical or dental service] contracts issued under NRS 695B.200, and blanket contracts issued under NRS 695B.220.

4. Unless every printed portion and any endorsement or attached papers are plainly printed in type of which the face is not smaller than 10 points.

5. Except for group [hospital or group medical or dental service] contracts and blanket contracts issued under NRS 695B.220, unless the exceptions of the contract are printed with greater prominence than the benefits to which they apply.

6. Except for group [hospital or group medical or dental service,] contracts and blanket contracts issued under NRS 695B.230, unless, if any portion of such contract purports, by reason of the circumstances under which an illness, injury or disablement is incurred to reduce any service to less than that provided for the same illness, injury or disablement incurred under ordinary

circumstances, such portion is printed in boldface type and with greater prominence than any other text of the contract.

7. If the contract contains any provisions purporting to make any portion of the charter, consitution or bylaws of such non-profit corporation a part of the contract unless [such] that portion is set forth in full in the contract.

8. Unless the policy provides, at the option of the subscriber, services for treatment of alcohol and drug abuse as provided in NRS 695B.195 [.] and section 7 of this act.

9. Unless [such] the contract for hospital service contains in blackface type, not less than 10 points, the following provisions:

Nothing contained in this contract shall in any manner restrict or interfere with the right of any individual entitled to hospital service and care hereunder to select the contracting hospital or to make a free choice of his attending physician, who shall be the holder of a valid and unrevoked physician's and surgeon's license and who is a member of, or acceptable to, the attending staff and board of directors of the hospital in which such hospital services are to be provided and rendered.

Sec. 9. NRS 695B.195 is hereby amended to read as follows:

695B.195 The annual benefits provided by all individual and group service or indemnity-type contracts issued by a nonprofit corporation, as required by subsection 8 of NRS 695B.180, for the treatment of alcohol [and drug abuse] shall consist of:

1. If the policies [are basic policies,] provide inpatient

benefits, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007, or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant of NRS 458.025, for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 10. Chapter 695C of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. The annual benefits provided by all individual and group health care plans, as required by subparagraph (5) of paragraph (b) of subsection 3 of NRS 695C.170, for the treatment of drug abuse must consist of:

(a) If the policies provide inpatient benefits, room and board in a hospital for a period of not less than 5 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during that period.

(b) If the policies provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025 for a minimum of 30 days with a maximum benefit of \$1,000.

(c) If the policies provide major medical coverage, outpatient treatment in a facility described in paragraph (b) for at least 52 visits with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to paragraph (b), treatment under this paragraph must commence within 7 days after the completion of the inpatient treatment.

2. An insured is entitled to:

(a) Two courses of treatment, as described in subsection 1;
and

(b) Sixty outpatient visits in addition to the visits provided for in paragraph (c) of subsection 1,
flush during his lifetime.

3. The centers, programs and staff for treatment must be licensed, accredited and certified, respectively, by the state.

4. Family counseling is appropriate outpatient care for the treatment of the abuse of drugs.

Sec. 11. NRS 695C.170 is hereby amended to read as follows:

695C.170 1. Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance

policy, whether by option or otherwise, the insurer shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

2. [No evidence] Evidence of coverage or amendment thereto shall not be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment thereto has been filed with and approved by the commissioner.

3. An evidence of coverage shall contain:

(a) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation or which are untrue, misleading or deceptive as defined in subsection 1 of NRS 695C.300; and

(b) A clear and complete statement, if a contract, or a reasonably complete summary if a certificate, of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner the services may be obtained;

(4) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay; and

(5) A provision for benefits, at the option of the enrollee, for services for the treatment of alcohol and drug abuse, as provided in NRS 695C.175 [.] and section 10 of this act.

flash Any subsequent change may be evidenced in a separate document issued to the enrollee.

4. A copy of the form of the evidence of coverage to be used in this state and any amendment thereto shall be subject to the filing and approval requirements of subsection 2 unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance in which event the filing and approval provisions of such laws apply. To the extent however that such provisions do not apply to the requirements in subsection 3, such provisions are amended to incorporate the requirements of subsection 3 in approving or disapproving an evidence of coverage required by subsection 2.

Sec. 12. NRS 695C.175 is hereby amended to read as follows:

695C.175 The annual benefits provided by all individual and group health care plans, as required by subparagraph (5) of paragraph (b) of subsection 3 of NRS 695C.170, for the treatment of alcohol [and drug abuse] shall consist of:

1. If the policies [are basic policies,] provide inpatient benefits, room and board in a hospital for a period not to exceed 10 days and all the necessary services, supplies, laboratory tests and X-rays which may be required during [such] that period.

2. If the policies [are basic policies,] provide inpatient benefits, inpatient treatment in a health and care facility, as defined in NRS 449.007 or in a treatment facility certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources pursuant to NRS 458.025

for a period of not more than 30 days with a maximum benefit of \$1,000.

3. If the policies [are] provide major medical [policies,] coverage, outpatient treatment in a facility described in subsection 2 for a period of not more than 180 days with a maximum benefit of \$800. If a patient has received inpatient treatment pursuant to subsection 2, treatment under this subsection must commence within 7 days after the completion of [such] the inpatient treatment.

Sec. 13. This act shall become effective on July 1, 1980.